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Save the Children

Burkina Faso Field Office

Local Institution Support for Child Survival Protective Behaviors

Sapone, Ipelce and Doulougou Departments Bazega Province, Burkina Faso

Detailed Implementation Plan

Child Survival 8

September 30, 1992 - September 30, 1995

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DIP TABLE A: COUNTRY PROJECT SUMMARY

PVO/Country BURKINA FASO Project Duration (mm/dd/yy) start date Sept. 30, 1992 estimated completion date Sept. 30, 1995

1. BUDGET SUMMARY IN U.S. DOLLARS

(a) a. By year of project	(b) A.I.D. Contribution (field + HQ)	(c) PVO Contibution (field + HQ)	Total Contribution (field + HQ)
Year 1	253,714	120,725	374,439
Year 2	257,798	66,300	324,098
Year 3	252,703	67,717	320,420
Country Project total	764,215	254,742	1,018,957

b. Percent of PVO Match: 25%
(PVO Contribution divided by Total Contribution: sum of column "c" divided by the sum of column "d")

2. SIZE OF THE PROTENTIAL BENEFICIEARY POPULATION

Note: POTENTIAL BENEFICIARIES are defined as those in the project area who are eligible to receive services for a given intervention, not the percent you expect to provide services to – which may be smaller than the eligible population.

(e) a. Current population within each age group*	(f) Number of Potential Beneficiaries
infants, 0–11 months	1,300
children, 12–23 months	1,050
children, 24–59 months	3,175
children, 60–71 months (if Vitamin A component)	975
females, 15–19 years (high risk pregnancy)	1,326
females, 20–34 years	2,955
females, 35–49 years (high risk pregnancy)	1,993
Other (specify) 10–14 females	1,811
Other (specify)	

b. Additional births	
Total estimated live births, years 2 and 3	2,700
c. Total Potential Beneficiaries	17,265

* Note: Females (ages 15–49) should only be included as potential beneficiaries where they are direct beneficiaries of services (for examkple, TT immunizations, or family planning services), and not for educational interventions (for example, education on proper use of ORT)

3. CALCULATION OF A.I.D. DOLLARS per BENEFICIARY per YEAR

a. Total A.I.D. Contribution to Country Project (sum of column "b" in table 1, this page)	764.215
b. Totd Potential Beneficiaries (sum of column "f" in table 2, this page)	17,265
c. A.I.D. Funding per Beneficiary for Project (line a. divided by line b. in table 3, this page)	44.21
d. A.I.D. Funding per Beneficiary per year (line c. above divided by 3 years)	14.74

4. PERCENT OF TOTAL A.I.D. CONTRIBUTION by INTERVENTION

Place percentages in shaded areas only; percentages must add to 100%

INTERVENTION	Percent of Project Effort %	Percent of A.I.D. Funds %
a. Immunization	2	15,284
b. Control of Diarrheal Diseases	40	305,686
c. Nutrition Education	25	191,054
d. Vitamin A	10	76,422
e. Control of Pneumonia	0	0
f. Maternal Care/Family Planning	20	152,843
g. Malaria Control	2	15,284
h. Other (specify) AIDS	1	7,642
i. Other (specify)		
j. Other (specify)		
TOTAL	100	764,215

NOTE: When using LOTUS 123. enter data In shaded areas only

DIP TABLE A: COUNTRY **PROJECT** SUMMARY TABLE (disk filename: WP\TABLEA-2)

i. ACTIVITIES: Circle all activity codes that apply for each intervention

ontrol of Diarrhea1 Diseases
1 = Distribute ORS packets
(2) = Promote use of ORS packets
(3) = Promote home-mix
(4) = Promote SSS home-available fluids
(5) = Dietary management of diarrhea
(6) = ORT training
(7) = Hand washing
Other _____
(specify)

nmunization
1 = Distribute vaccines
2 = Immunize mother/children
(3) = Promote immunization
(4) = Surveillance for vaccine preventable diseases
(5) = Training in immunization
Other _____
(specify)

lutrition
1 = Distribute food
2 = Provide iron, folk acid, vitamins
(3) = Provide scales and growth charts
4 = Sponsor mother-to-mother breastfeeding/promotion support groups
(5) = Conduct food demonstrations
(6) = Counsel mothers on breastfeeding and weaning practices
(7) = Conduct group sessions
(8) = Training in breastfeeding and weaning
(9) = Training in maternal nutrition
(10) = Training in growth monitoring
Other _____
(specify)

Vitamin A
1 = Vitamin A deficiency treatment
(2) = Vitamin A supplementation
3 = Vitamin A fortification
(4) = Vitamin A education
(5) = Vitamin A food production
Other _____ (specify)

e. Control of Pneumonia
1 = Promote antibiotics
2 = **Health** education
3 = Improve referral sites
4 = Training
Other _____
(specify)

f. Maternal **Care/Family** Planning
1 = Distribute contraceptives
(2) = Promote exclusive breastfeeding to delay conception
(3) = Promote child spacing or **family planning**
(4) = Antenatal care
(5) = Promote malaria **prophalaxis**
(6) = Train **TBAs** in improved birth practices
(7) = Family planning **training**
Other _____
(specify)

g. Malaria Control
(1) = Residual insecticides
2 = **Larvaciding**
3 = Provision of bednets
4 = Provision of commodities
5 = Treatment
(6) = Health education
(7) = Training
Other _____
(specify)

h. Other **Specify**
AIFS
_____
_____
_____
_____

SECTION **B. Location and Formal Agreements**

B.1 The project will be located in Burkina Faso, Bazega Province, in 26 villages of Sapone, Ipelce and Doulougou Departments, a poor rural setting. The project area is within 40 km South of the capital, Ouagadougou, therefore there are some peri-urban characteristics, such as high population mobility and availability of nearby urban markets. (See attached maps, Appendix 1.) Approximately 25,000 persons live in this rural, Sahelian area, (Source: National census, 1985). The impact area is dominated by the Mossi ethnic group. The area is a mix of religions; Moslems, Christians, and Animists. Infant mortality rates are high (135/1000) and literacy rates of mothers are low (6,7%). GNP per capita income is low: $210 per year.

B.2 Burkina Faso's infant mortality rate is 135/1000, with an under-five mortality rate of 232/1000 (UNICEF, 1991). These are the eighth highest rates in the world. In Bazega Province of Burkina Faso, vaccination coverage was estimated at 30% in 1988 (MOH). A recent MOH survey (199 1) showed coverage had increased to 62 % . ORS packets are available at health centers, but use of ORT at the village level is still quite low and diarrhea is still a major health problem (health center records). Access to safe water in Burkina Faso is limited to 69% among the rural population. The number one reason for health center visits in Sapone was for malaria treatment (health center records); malaria is a serious problem throughout the year, and treatment is not always easily available.

In Bazega Province food availability is hampered by a short growing season. Limited rainfall in the region (800 mm/year) in general makes year-round food security non-existent. Growth monitoring in Sapone/Ipelce in 1991 showed 31% of children under 80% of standard weight-for-age, indicating that malnutrition is widespread (Save the Children growth monitoring records), Vitamin A deficiency rates are not available, but night blindness is well-known in the area. WHO lists Burkina Faso as one of the high prevalence countries for vitamin A deficiency. Closely spaced births are common, and contraceptive use is very low. HIV seroprevalence in Burkina Faso has been measured at 3.7% among pregnant women and 10% among blood donors (MOH); fairly high population mobility and lack of knowledge about prevention favors AIDS transmission in the project area. There are no functional Village Health Committees (VHCs) in the project area, and literacy rates are very low.

The level of community organization is high. The region has a history of self-help, in which Save the Children has played a part since it came to the area. Combined with the obvious needs of the area, the potential for a successful community development approach to solving problems led Save the Children to choose Bazega Province for a child survival project. The health system infrastructure is limited to 4 health centers and maternities.

B.3 Save the Children has a long term agreement signed with the government of Burkina Faso on 26 July 1975. SC has an active health agreement with the MOH signed on 14 February 1990. The project is also working to sign a formal agreement with the local health authority of Bazega province. The project DIP will be a part of the documentation needed to present the agreement for signature. These agreements allow SC to operate in Burkina, provide it with tax privileges, and specify the geographic and programmatic areas of intervention. Other collaborating institutions and PVOs include; the Sapone, Ipelce and Doulougou health centers; the Bazega provincial health director; the nutrition department of the national family health directorate; and the national malaria control program; Sapone-Developpement-Solidarite, Association Burkinabe pour l'Action Communautaire (ABAC), Association pour le Developpement du Departement de Sapone, Association Vive le Paysan (AVLP), Association pour le Developpement du Village de Kalzi, Helen Keller International, Johns Hopkins University, and the SEATS project. To date, SC have local NGO staff from ABAC and AVLP working to help develop the DIP and implement project activities. They will continue to work closely with Save the Children personnel throughout the life of the project.

SECTION C. DIP Sustainability Strategy

C.1 SC/BF aims for sustainability at three levels: (A) Individuals sustain changes in their health (and other) behaviors when they perceive that these changes lead to lasting benefits which outweigh their costs. Behavioral change arising from increased and wide dissemination of knowledge leading to creating new community norms is the foundation of SC/BF's sustainability strategy. (B) Strengthening indigenous institutions to promote the new behaviors, especially among those individuals who might not otherwise adopt them. Such institutions can also ensure some level of quality control and can make improvements in messages and behaviors when necessary. SC/BF's greatest contribution to local institution-building is its plans to work with VHCs and women's groups. This extends beyond merely training them in child-protective behaviors, to training in functional literacy and numeracy, record keeping, management, and problem-solving skills. SC/BF will support local PVOs, MOH, and other local institutions. (C) Government Policy Change to support the new behaviors. SC/BF has and will continue to disseminate project findings as often and as widely as possible among government agencies, and welcomes opportunities to discuss them with key officials.

SC/BF's strategy of village self-management for health places the village in the role of main health-enhancer; it is the VHCs who will be called upon to maintain the HIS and train their own community members in protective behaviors. The role envisioned for the MOH in sustaining CS benefits is to be responsive to the informed service demands of VHCs, and SC has concentrated work with the MOH on skill enhancement, motivation, and linkages with key community members involved in health.

Participating local PVOs will gain the capacity to sustain and expand project interventions, and to raise funds to continue their work through a planned process of transfer of skills and knowledge.

Several indicators will be used to monitor project progress towards sustainability: # and % of mothers adopting the following behaviors: seek EPI services, use ORT in the treatment of diarrheal episodes, provide enriched food to their malnourished children, consume vitamin A rich food, treat malaria with chloroquine, seek prenatal care when pregnant, maintain cleanliness of wells. # and % independently functioning VHCs, # and % villages supporting their promoters, # and % VHCs with at least one literate person/woman, # of active women's groups in promoting health behaviors. # PVO partnerships, # trained MOH personnel. # of PVOs expanding health activities. # meetings held with community leaders, health center chief medical officer, regional and national MOH key policy makers where policy or procedural change has been discussed.

C.2 Through discussions with community leaders and women's groups, infant and child mortality and morbidity due to malaria, diarrhea, malnutrition, and vaccine-preventable diseases are the perceived major health problems. Also, women are interested in child spacing but need more information and access to services. The project incorporates responses to all of these health priorities, while also addressing the economic, literacy training, and water needs of the communities. To foster community ownership and maintain a level of active public support, the village will plan specific village activities with community members. Before the family enrollment begins, the project coordinator will work with village leaders and women's groups to identify their needs, and develop strategies. The sustainability of each of the developed strategies will be discussed by the project coordinator with community members before being agreed upon. Project personnel will be living in the villages and will work mostly with women and families. They will have first hand knowledge of the level of public Support for project activities. Village chiefs, and the administrative and traditional authorities were consulted on project activities before the development of the DIP.

C.3 All project activities will be coordinated with the Regional and Local health authorities, in order to ensure efficient collaboration. The project will integrate and build on the experiences of ACNM in TBA training; PRITECH in ORT support; and Nutricom, once their materials development is complete; as well as local PVOs. This is also true for MOH efforts, which have begun to support TBAs and CHWs (including sales of medicines and condoms) but which have not been sufficient to render these agents truly functional. Most existing efforts by partner agencies are based at the health center level; SC's community-based activities will be complementary, not duplicative. Due to this collaboration with MOH personnel, the project expects a large transfer of skills and knowledge to occur. The project will also collaborate with two local PVOs (AVLP and ABAC) to transfer knowledge and skills. Two of the project's promoters are employees of the local PVOs, one from each. It is expected that by the end of the project, they will take back with them skills and lmowledge that allow them to start their own program. SC will assist the local PVOs to secure their own funding. MOH personnel on the national and local level will be involved in every step of project implementation. MOH, AVLP, and ABAC personnel participated in the development of the DIP.

C.4 Project responsibilities will be transferred to village based institutions from the start. VHCs and family representatives will take a leading role in implementing project activities. The MOH personnel input will be directed towards supporting those local entities. The project role is to catalyze this process, and tin local PVOs to continue that catalytic role in the future. Community based organizations will be engaged in training programs in organizational management, economic development, and literacy. This will strengthen their management skills, and improve their ability to sustain the activities.

C.5 Most expected outcomes of this initiative relate to knowledge, skills, and behaviors that the mothers and other community members will acquire, and adopt. Child-protective behaviors in ORT, EPI, proper weaning, appropriate nutrition, Malaria control, environmental hygiene, and literacy training should be maintained at no cost. The CS project also receives in-kind contributions from village households in the form of grain and other foods used in demonstrations. Services provided by the TBAs are already rewarded and the work of the VHC members is on a voluntary basis. Immunization costs will be covered by the national EPI program. Recurrent cost of the HIS will be covered by village funds generated through selling chloroquine, contraceptives, and other commodities. Cost recovery at both village and health center level involving basic medicines and contraceptives will help ensure continuing re-supply and will generate small profits. Village credit and savings activities will be expanded to cover further villages. It is not expected that the central computerized HIS will continue over the long term. The MOH will continue to fund the functioning of the health centers and ongoing supervision of TBAs and CHWs; and it is expected that UNICEF will continue to support the national EPI. The project manager will be the key person responsible for ensuring the sustainability of the activities, including cost recovery mechanisms. Technical assistance for cost recovery will be provided by the Field Office Director or other SC Headquarters and field technical personnel.

SECTION D. Project Design

D.1. The survey found that 99.6% of mothers breastfeed their children. For the growth monitoring intervention the survey found that only 28% of the children had been weighed in the last 3 months. The survey also found that only 5.8 % of children had been given at least one dose of Vitamin A. For the malaria intervention, 87.2% of mothers said they should bring their child to a health clinic and/or give chloroquine if the child has a fever. 61.3% of mothers did not know how to protect themselves and their families from getting malaria. Of the mothers that reported their children as having had diarrhea in the last two weeks, 77.8% gave liquids as usual or more than usual. 45.3% asked for advice or treatment for their child's diarrhea. For immunizations the survey showed a complete vaccination coverage rate of 61.3%

among children between 12-23 months. 80.8% of mothers had received 3 or more tetanus vaccinations. 46.3% did not know what the tetanus vaccine was for. In maternal health, the survey found that 71.7% of mothers had had no prenatal visits during their last pregnancy, even though 41.7% reported that they think they should see a health agent at least twice during a pregnancy. 68.3% of mothers were assisted during their delivery (cut umbilical cord) by a traditional birth attendant. Of the 11.3% of women who reported using birth control (either themselves or their husbands), 48% of them use abstinence as their principle method. 94.6% of mothers interviewed in the survey had heard of AIDS. 75.8% of those women knew at least one method to reduce the risk of AIDS.

D.2. The Goal is to achieve a " Sustainable reduction of morbidity and mortality of children under five years of age".
By August 1995, the following objectives will be achieved:

CONTROL OF DIARRHEAL DISEASES (40%)
* 80% of families will have at least one member competent in Oral Rehydration Therapy (including home available fluids, proper feeding and referral).
* 80% of Village Health Workers will be competent in case management of diarrheal diseases.

NUTRITION AND VITAMIN A (35%)
* 60% of mothers of children under 24 months will be competent in proper weaning, and in feeding children appropriately for age.
* An appropriate megadose of Vitamin A will be provided to 70% of children 6-59 months (every six months) and to 60% of immediately postpartum women.

HIGH RISK BIRTHS (20%)
* 75% of high risk pregnancies will receive two prenatal and one postnatal visits, and will be assisted at delivery by a trained birth attendant who is appropriately equipped.
* 90% of women of child-bearing age will have received at least 2 doses of tetanus toxoid.
* 80% of TBAs and CHWs will be able to inform and refer families with respect to family planning techniques and AIDS prevention.
* 50% of the population lo-49 years old will know at least one effective method of AIDS/STD prevention
* 50% of couples will know how to procure and use at least one modem method of child spacing.

OTHER INTERVENTIONS (5%)
* Immunization: 80% of children 12-23 months will be completely immunized.
* Malaria Control: 80% of CHWs will be able to inform and refer families with respect to prevention and treatment of malaria.

The objectives have been revised from the proposal based on the results of the baseline survey, lessons learned from past SC interventions in the Sapone area, and the recommendations of the local USAID mission. Baseline data permitted in-depth analysis of each component, determination of current status, and development of achievable objectives based on available time and resources.

INPUTS	OUTPUTS	OUTCOMES
CONTROL OF DIARRHEAL DISEASES		
5000 mothers trained in ORT preparation 26 VHWs trained in traning mothers on ORT, monitoring ORT use, and clean water use	4000 mothers use ORT in treatment of diarrhea, and use clean drinking water. Water source is cleaned and maintained	Reduction in diarrhea related mortality
NUTRITION AND VITAMIN A		
3500 children weighed quarterly; 1650 mothers trained in weaning food preparation; 1200 mothers attending food demonstration; 4500 children 6-59 and 2400 mothers receiving Vitamin A capsules; 26 VHCs trained in home gardening	1650 mothers can correctly read growth chart, and act accordingly; 1200 mothers practice proper nutrition and growth promotion behavior; 20 new home gardens initiated	Increase in # & % ofchildren who were growth faltering, and have gained weight. Reduction in rate of vitamin A deficiency.
HIGH RISK BIRTHS		
26 TBAs will be trained; 2450 couples trained in child spacing; 650 women 12-49 trained in protective behaviors for pregnancy and motherhood	975 preg. women will receive pre & postnatal care & will have assisted delivery; 2450 couples will know how to use modern contraceptives	Reduction in rate of maternal mortality. Reduction in age specific fertility rate.
IMMUNIZATION		
5000 children U5 fully immunized; 5000 women of CBA fully immunized	Reduction of # of reported cases of immunizable diseases	Reduction in the ratio of child mortality due to immunizable diseases
MALARIA CONTROL		
26 CHWs & 3000 families trained in Malaria prevention and treatment	2500 families will adopt Mal. prevention methods	Reduction in the ratio of child mortality due to Malaria

Baselinedataprovided an understanding ofthecurrent status for each component. Project objectives were revised upward or downward according to whattheprojectcan achieve in its lifetime (3 years), and within its resources. Both quantitative and qualitative data were used to make thebestjudgementpossible for each objective.

D.3. The proposed project will build the capacity of local institutions to promote child protective behaviors. At the district level, it will create a tripartite collaborative effort composed of the MOH, two local PVOs, and SC, through which the project will improve the capacity of the local PVOs to collaborate with the communities and the MOH to identify community health needs, develop a work plan, acquire needed resources, and implement planned health interventions. At the community level, the project will promote the development of VHCs and family representatives to improve their ability to identify community health needs, and seek appropriate assistance.

The project will train and equip local TBAs and VHWs. It will assist the creation/promotion of women's groups which will be a main driving force behind the promotion of the new behaviors. It will also promote community activities that will improve the ability of the families to adopt the new health behaviors, such as home gardening, income generation, cereal banks, literacy, digging wells, and building latrines. Training of local PVO and MOH personnel will also improve public and private sector capacity to provide primary health care services.

The project will be implemented in 26 villages of the Sapone, Ipelce and Doulougou Departments of Bazega Province in Burkina Faso. The total population in the target area is approximately 25,000. It includes 5,525 children under five, and 7,788 women aged 10-45.

KEY INTERVENTIONS: Control of diarrheal diseases (tin families, women's groups and CHWs in ORT, proper feeding, and referral; promote appropriate hygiene; VHCs to monitor proper CDD practices). Nutrition/Vitamin A (growth monitoring for children < 3 years; nutrition education/demonstration workshops; distribute Vitamin A capsules; promote home gardening, conservation, and consumption of green vegetables). High risk births (train TBAs in pre/postnatal care, micronutrient deficiency, child spacing, AIDS prevention methods, risk factors for pregnancy requiring evaluation).

Other Interventions; Immunization (mobilization of unvaccinated children/women through HIS rosters; support MOH in EPI services and training). Malaria control (malaria prophylaxis and treatment, pilot efforts in treated bednets and destruction of breeding sites).

In Bazega Province, vaccination coverage was estimated at 30% in 1988 (MOH). A recent MOH survey (1991) showed coverage had increased to 62 % . The number one reason for health center visits in Sapone was for malaria treatment (health center records); malaria is a serious problem throughout the year, and treatment is not always easily available. ORS packets are available at health centers, but use of ORT at the village level is still quite low (exact figures not available) and diarrhea is still a major health problem (health center records). Access to safe water in BF is limited to 69% among the rural population. Growth monitoring in Sapone/Ipelce in 1991 showed 3 1% of children under 80% of standard weight-for-age, indicating that malnutrition is widespread (Save the Children growth monitoring records). Vitamin A deficiency rates are not available, but night blindness is well-known in the area. WHO lists BF as one of the high prevalence countries for vitamin A deficiency.

Births are still often unassisted by trained personnel, and high risk and difficult births are rarely evacuated or referred early enough. Closely spaced births are common, and contraceptive use is very low. HIV seroprevalence in Burkina Faso has been measured at 3.7% among pregnant women and 10% among blood donors (MOH); fairly high population mobility and lack of knowledge about prevention favors AIDS transmission in the project area. There are no functional Village Health Committees (VHCs) in the project area, and literacy rates are very low.

D.4. In general all members of the target population will enter and participate in the child survival activities. The HTS described in section E will be used to identify eligible women, children, and newborns. A project monitoring system will be developed by the project coordinator. Data needed to satisfy the system will come mainly from the HIS (see section E), and from the MOH service statistics records. A monitoring report will be developed every 3 months. Review of these reports over time will allow the project coordinator and the field office director to monitor project progress, and allow changes to be made in a timely fashion.

D.5a - DIP for Immunization (EPI)

5a.l Baseline data shows the following imunization coverage rates among children 12-23 months; BCG 92.5%, DPT3 78.3%, Polio3 77.4%, Measles 74.5%, and Yellow Fever 67.0%. Drop-out rate for DPT is 16.2% [(93.4-78.3)/93.4]. 61.3% are completely immunized. Those are the children who have received BCG, DPT3, Polio3, Measles, and Yellow fever vaccines. 80.8% of women of child-bearing age have received 3 Tetanus Toxoid or more, 89.6% have received 2 or more. Therefore we can estimate that at least 80.8% of newborns are protected against tetanus.

5.a2 Among all the mothers, 90.4% knew that their child was vaccinated, 21.7% knew that nine months is the correct age to vaccinate the child against measles. 37.5% of the mothers knew that the main reason for a pregnant women to be immunized with tetanus toxoid vaccine is to protect the mother and the newborn against tetanus. Almost 72.9% of the mothers said two or more tetanus toxoid injections are needed to protect the mother and the newborn from tetanus. 87.9% of the children, and 90.8% of the mothers had a vaccination card.

5.a3 The MOH recommends the immunization of children during their first year with BCG, DPT, Polio, Measles, and yellow fever, and women of CBA with Tetanus Toxiod. Beneficiary population are children under five (5,525) and women of child bearing age (5,977). An estimate breakdown by age is in table A. Each child needs 5 visits before his first birthday, and each women of CBA needs 2 visits with appropriate intervals to be completely immunized. The government strategy of monthly visits is adequate. A high nsk for immunization means a child who is not completely vaccinated by age one, and a women of CBA who does not have at least 2 TT vaccines before delivery, or did not receive a TT vaccine during the last 5 years.

5a.4 The project's immunization objective is to have 80% (4,420) of children completely immunized, and 90% (5,379) of women of child-bearing age having received at least 2 doses of Tetanus Toxoid. During year one, the project will work in 18 villages with an estimated population of 15,000. With 936 newborn, and 60% of the children fully immunized, the project will promote the vaccination of 2,416 children, and 1,03 1 women of CBA. During year 2, 1,832 children, and 727 women of CBA, and during year 3, 1300 children, and 450 women of CBA will be vaccinated.

5a.5 The project's immunization strategy is to strengthen the MOH existing immunization campaign (5a.3), and increase access of mothers to the immunization services. The MOH promotes an immunization strategy that consists of 2 components: (1) Vaccination at fixed centers conducted on a daily basis, and with every contact. This is mainly for the population living within a 5 kilometer radius; and (2) Vaccination via mobile teams on motorcycles for villages in the 5-10 kilometers radius, and on vehicles for villages beyond the 10 kilometers radius. Each village is visited monthly by the mobile team. The project's strategy to increase access of mothers will be carried out by VHWs, and village animators who will be engaged in a campaign to increase mothers' knowledge of immunization. This will be conducted in village based health education and promotion sessions, village meetings, and women's groups, followed by home visits to reinforce the messages. Before the arrival of the vaccination

teams, an invitation card to attend the immunization will be given to mothers of eligible children. Those will be identified through the HIS described in section E. During the immunization sessions, VHWs and animators will assist the mobile team to organise the sessions, fill out the vaccination cards, and call upon eligible mothers who did not come. They will also provide feedback to the community, and the MOH on the coverage status which they will compute using the HIS. Mothers who did not attend will be visited for further mobilization for the next mobile team visit. Support for the MOH will include fuel for the vehicles, petrol for the refrigerators (cold chain), and training of staff. Inputs, outputs, and outcomes are in point D.2. Immunization activities will be phased in. The project will began in Year 1 in 18 villages, and add the remaining 8 in year 2. All immunization activitieswill begin at once in a given village. Beneficiaries can access immunization service all year if they go to the 4 fixed centers of the area.

5a.6 Technical oversight for immunization will be provided by the local medical officer (Marcel Ouedrago). The project manager (Jean-Pierre Bembamba) will be responsible to maintain the technical quality of its interventions, and for the quarterly monitoring system.

5a.7 Eight promoters, 21 MOH personnel, 52 VHWs, and 228 family representatives will be trained in immunization promotion and/or delivery, All will receive 21 hours of training that include their specific responsibilities. The focus will depend on their role in the immunization process. MOH personnel will review correct administration of immunization. Promoters will be trained on community organization and mobilization. VHWs and family representatives will be trained in training and motivating mothers. Immunization training will be conducted during the first 6 months of the life of the project. Training of promoters was completed. Training of VHWs will be conducted in March or April. Evaluation of the success will be carried out through the monitoring system, the midterm, and the final evaluations. Data generated by the HIS will be tabulated, analyzed, and used quarterly to report on the monitoring system indicators.

5a.8 MOH/EPI immunization card in appendix 4. This is the card the project is using. The HIS child roster (see section E), and the village immunization book will be used in case an immunization card is lost. Immunization data will be recorded on vaccination cards, HIS rosters, village immunization book, and MOH/EPI book. Cards will be bought from the MOH. Budget provisions for the HIS costs including all forms and cards have been made accordingly.

5a.9 To reduce drop out rates, the MOH/EPI program developed a policy of daily vaccination and vaccination with every contact in the fixed center, and monthly visits by the mobile units. Also, even if a single dose is needed to immunize one child, a bottle is opened. It is called useful loss. The project will use its 100% family enrollment system (see section E) to promote the use of the immunization services, provide invitation cards to eligible women and children, and track defaulters through home visits.

5a.10 Same as 5.a9

5a. 11 Availability of kerosene for refrigerators is a weak link. Needed petrol supplies will be supported by the project. The MOH is responsible for maintaining the cold chain. The project will work closely with the MOH personnel to ensure its reliability. Detected weaknesses will be addressed with the appropriate authorities. If a need such as training and/or supervision of cold chain personnel arises, the project will support it. With the exception of kerosene, MOH/EPI is providing all needed equipment, and supplies for cold chain maintenance.

5a. 12 The MOH/EPI has a functionning disease surveillance system for preventable diseases.

It relies mainly on service statistics. The project, through the promoters and the VHWs, will identify the same diseases at the community level. Data collected will be fed to the MOH system. Surveillance data from the MOH will be also accessed by the project. The HIS coordinator will be responsible for tabulation and analysis. Results of the analysis will be discussed with communities, and MOH regional authorities for appropriate action.

D.5b - DIP for Diarrheal Disease Control (CDD)

5b.l The number of diarrheal episodes per child per year varies widely with the season. It is most prevalent during the peak of the rainy, and dry seasons, Average number however, is 2-5 episodes per child per year, Average number of days per episode is 3-5. (estimated data from VHWs)

5b.2 Respectively 64.7%, 44.2%) 28.7% of the mothers whose children had diarrhea in the last two weeks declared they breastfed their child same or more that usual, gave same or more fluid than usual, gave same or more food than usual. None of the mothers stopped giving breastmilk, or fluids during diarrhea. 89.5% of mothers gave some form of treatment to their child. 5.3% gave sugar salt solution, 17.9% gave herbal teas or other fluids, 6.3% gave anti-diarrheal medicine or antibiotics, 27.4% used ORS packages, and 1.1% gave cereal-based ORT. 45.3% of the women sought advice or treatment for the diarrhea; 48.8% at the health center, 20.9% with the village health worker, 11.6% with the traditional healer, and 9.3% with the traditional birth attendant, and 7.0% with parents and friends.

Concerning the knowledge of diarrhea symptoms requiring referral, 28.5% of the mothers did not know any of them; 15.4% knew dry mouth, sunken eyes, decreased urine as important symptoms of children's dehydration, 29.9% diarrhea of prolonged duration, 7.2% weakness or tiredness, 2.7% loss of appetite, 3.6% vomiting, and 11.3% fever. As for knowledge regarding important actions a mother should take if the child had diarrhea, 6.3% did not know. Among the other 93.7%, .8% would give to the child more to dnnk than usual, 71.3% take the child to the hospital/health center, and .8% give the child smaller, more frequent feedings, and 17.5% take other actions. As for the action to take when a child is recovering from diarrhea, 26.4% of the mothers declared they would give more foods than usual, and 38.9% give the child smaller, more frequent feedings.

5b.3 MOH protocol for case management of diarrhea is appendix 2. The MOH promotes home available fluids, and ORS packets.

5b.4 Project objectives for controlling diarreal disease is to have 80% of families have at least one member competent in Oral Rehydration Therapy (including home available fluids, dietary management, and referral of severe cases), and 80 % of Village Health Workers competent in case management of diarrheal diseases. The project expects that 60% of mothers of children with diarrhea in the previous 2 weeks will treat them with ORT.

5b.5 Breakdown of women of CBA by age is in table 1. 5,977 women of CBA will be trained to treat diarrhea. The beneficiaries will be the 5,525 children under 5. The project will ensure at least one contact per woman per year. This will be monitored through the HIS. (Section E) High risk for case management of diarrheal diseases means children under 2, malnourished children, children in villages without a nearby water source, children living in non-hygienic conditions, and children of single mothers.

Sb.6 The project strategy for CDD will include training mothers and other caregivers through health education sessions in villages and health centers, women's groups, village meetings. Messages will be reinforced via home visits. The HIS will be used to ensure that each woman

receives at least one contact per year for CDD messages. The project will stress early initiation of fluids, increased frequency of fluids, proper measuring and administration of ORS, more frequent small feedings during and after diarrheal episodes. Home management of diarrheal diseases is appendix 2. See section D.2 for planned inputs, and expected outputs and outcomes for CDD. Project activities will start in 18 villages during the first year, and will expand to the remaining 8 villages in year 2.

5b.7 Beneficiaries can easly access ORS packets. Their availability is assured by the MOH. VHWs get their supplies from the health facilities which are constantly restocked by the MOH through its national, provincial, and local infrastructure. ORS packets are distributed free by the MOH. Beneficiaries can access them at any health facilities. At the village level, VHWs are allowed to charge 10 F.CFA (4 cents) at the village level to cover their cost.

5b.8 Advice to use cereal based ORT will include the enriched porridge (bouillie), and/or rice water. Other infusions used include herbal teas, and the fruit of the Baobab tree (Pain de Singe). Those are available at the household levels. SC/Burkina nutritionist (Clement Bouyain) will examine their caloric contents, and develop recommendations for exact messages.

5b.9 The national diarrhea program has developed a treatment protocol for CDD (Appendix 2). Once the child reaches a health facility, and a diagnosis is made, the child is classified into A, B, or C. Treatment plans for each category are well explained, and usually carried out. Health center staff complain however about the amount of paper work that takes about 20 minutes to complete. The plan is comprehensive and sufficient. The project will follow it.

5b.10 Messages to mothers are in plan A (appendix 2). Health workers will use posters, flash cards, and flanelographs (GRAAP) to communicate with mothers. Educational sessions will be organised by the villagers. It will be in the form of health education sessions, village meetings, women's groups, or home visits. A simplified pre-/post-test method will be used to assess the amount of knowledge the mothers acquire. This will be reinforced through the monitoring system and the midterm and final evaluations. The project will use what the MOH developed for the national CDD program.

5b. 11 Other diarrheal disease control strategies include general hygiene within the village environment, hand wasing with soap before handling food, cleanliness of water points, and disinfecting the wells. Mothers will be trained in acquiring, transporting, and storing water in a clean way. Water activities will be carried out by SC water sector currently active in the project area. Needed supplies and equipment will be the responsibilities of that sector,

5b. 12 Technical oversight of the project CDD component will be the responsibility of the project manager Jean-Pierre Bembamba who will be assisted by the project supervisor Mathias Nikiema. The 8 promoters and their supervisor will monitor mothers' knowledge of correct ORT. Project manager and supervisor will supervise the quality of health workers' instruction to mothers regarding home management of diarrheal diseases.

5b.13 The project will train 228 family representatives, 52 CHWs, and 8 promoters for the promotion of proper case management of diarrhea and any other specified CDD strategy. All will receive 21 hours of training that include their specific responsibilities. Promoters will be trained in community organization and mobilization. VHWs and family representatives will be trained in training and motivation of mothers. CDD training will include prevention, diagnosis, and management of diarrheal diseases, and appropriate nutritional practices during and after an episode. CDD training will be conducted during the first 6 months of the life of the project. Training of promoters was completed. Training of VHWs will be conducted in March or April. Evaluation of success will be carried out through the monitoring system, and

the midterm and final evaluations. Data generated by the HIS will be tabulated, analysed, and used quarterly to report on the monitoring system indicators.

5b.14 The project will use its 100% family enrollment HIS to allow the promoters to record whether a mother has been taught proper measuring and administration of ORT, and given other important messages for home management of childhood diarrhea.

D.5c - DIP for Nutritional Improvement

5c.1 No current estimate of malnutrition rates is available (see Section D.3. for 1991 data). The project will conduct growth monitoring activities to identify mothers with malnourished children, and provide them with necessary nutritional knowledge and skills. The project will follow the MOH policy in identifying malnourished children. Food availability issues will be addressed by the project through activities such as supporting cereal banks.

5c.2 In the Sapone area food availability is hampered by a short growing season. Limited rainfall in the region (800 mm/year) in general makes year-round food security non-existent. Sapone is still recovering from the droughts in 1985 and 1987, combined with low levels of rainfall last year.

5c.3 The baseline survey done in the Sapone area showed that 93.3% of the mothers interviewed declared that they breastfed their children but only 7% conduct exclusive breastfeeding. Traditionally, colostrum is thrown away because it is not considered good milk for the child. Almost 50% of mothers with children over the age of 6 months have added food such as eggplant, beans, shea butter, fish, peanuts, baobab leaves, and meat, to their children's diets. In the age group 6-9 months 84% of the mothers declared that they give porridge to their children. 67.1% of mothers knew that they should give food in addition to breastmilk beyond four to six months; of these, 7.5 % said they start adding food six months or later. 79.7% of the mothers knew that they should add oil (Shea-nut butter) to the porridge. 35.8% knew that they should give the child food rich in iron, and 5% food rich in vitamin A. 72.1% of the children had a growth monitoring card, Among these children 39.3% were weighed at least once in the last three months. 65.6% of the mother knew that they should seek advice if the child was below the curve on the growth monitoring card. 35.7% said they would go to the health center. 5.8% received at least one vitamin A capsule.

5c.4 The number of the beneficiaries eligible for nutrition interventions includes 3,500 children under three. The children will be weighed quarterly. During the weighing, mothers with malnourished children will be asked to attend nutrition education and demonstration sessions. Therefore, the number of contacts per mother per year could be averaged out to six. Eligible children will be identified through the family enrollment. (see section E for details). At high risk for nutrition are children who are below the 80th percentile of weight for age or are growth faltering.

5c.5 Project objective for nutrition states that 60% of mothers of children under 24 months will be competent in proper weaning, and in feeding children appropriately for age.

5c.6 The project's strategy for improving nutritional status of infants and weaning age children is focused around training mothers in good nutrition for their children. The project will be phased in over 3 years to include 28 villages with a total target population of approximately 3500 children and their mothers or caregivers by the end of the current CS VIII funding, In the first year we will tram 350 mothers, in the second year 800 mothers, and in the third year 1200 mothers.

The constraints on attempts to improve children's nutritional status in the project area include; poor distribution of food in the country as a whole (the southern part of the country is fertile, but the land becomes progressively more desert-like to the north; inadequate infrastructure hampers efforts to alleviate this imbalance); health practices of mothers and fathers; nutritional knowledge of mothers; and seasonal availability of food. Training mothers especially, to recognize and treat illnesses will increase the chances for children to survive and thrive. The project also includes a component to build and set up gram banks to address the problem of seasonal availability of most foods. Home gardening will be encouraged as well.

See section D.2 for details on planned inputs, expected outputs, and expected outcomes for the child nutrition component of the project.

5c.7 The project will train mothers in growth monitoring and good nutrition to address low birth weight babies.

5c.8 The strategy for improving nutritional status of pregnant and lactating women will focus on training mothers in good nutrition and health practices. Constraints on attempts to improve the nutritional status of these women are the same as those stated in question 5c.6; seasonal and regional food availability, and lack of knowledge in health and nutrition. As stated above, the project includes a component to establish grain banks to address the problem of seasonal availability of most foods. Home gardening will be encouraged as well. Nutrition activities will be phased in over the course of the project. (See 5c.6 for details.)

See section D.2 for details on planned inputs, expected outputs, and expected outcomes of the maternal nutrition component of this project.

5c.9 The project does not have a supplementary food component.

5c. 10 The project manager (Jean-Pierre Bembamba) will be responsible for the technical oversight of the nutrition component. He can access technical assistance from Clement Bouyain, Nutritionist and Dori health project manager, when needed. Dr. Ahmed Zayan, Headquarters health unit acting director, will visit the project at least once a year to provide technical assistance for improving the nutrition component.

5c. 11 The project will provide mothers with knowledge of appropriate nutrition and health practices. It will focus on helping mothers recognize and treat the most prevalent illnesses threatening themselves and their children. The strategy will use a combination of demonstrations, practice, songs, and role play, all adapted to cultural settings, to communicate this information.

Vitamin A Prevention

5c.12 No data is available on the prevalence of vitamin A deficiency, night blindness, in Burkina Faso. WHO, however, classifies Burkina Faso as a high prevelance country for vitamin A deficiency.

5c.13 The baseline survey showed that 62.1% of women knew of night blindness, but 92.6% did not know how to prevent it. 5.8% of the children had at least one dose of vitamin A capsule. Data also shows 45.8 % of women give their children food rich in vitamin A, and 76.5% add vitamin A rich food to their diet. Sapone is an arid area. It relies on one agricultural season. Staple food is millet. Despite its proximity to the capital, vitamin A rich food is seldom available.

5c.14 The beneficiary population for vitamin A capsule distribution is as follows: for children

12 to 59 months old 200,000 I.U., for children 6 to 12 months old 100,000, and for immediately postpartum mothers 200,000 within 2 months after delivery. Approximately 2 visits per year per beneficiary will be needed to reach full coverage for target groups.

Women and children will be enrolled in the program using the existing family registration records and procedures and updating the information on a regular basis starting from the beginning of the project.

5c.15 Project objective for vitamin A is to give an appropriate megadose of Vitamin A. It will be provided to 85% of children 6-59 months (every six months) and to 60% of immediately postpartum women. Therefore 4,500 children and 2,400 mothers will receive a megadose of vitamin A capsules. Children will be given a dose every six months, and women will receive a dose within the 2 months after delivery.

5c.16 The vitamin A strategy will be carried out by Save the Children health promoters in conjunction with the local health clinic. Save the Children organizes capsule distribution in conjunction with baby weighing sessions. Mothers will receive their capsules from traditional birth attendants who will be trained by the local health clinicians. Dosage: Children 6 - 12 months will receive 1/2 capsule = 100,000 I.U.; Children 13 - 59 months will receive 1 capsule = 200,000 I.U.; and Mothers (just having given birth) will receive 1 capsule = 200,000 I.U. UNICEF will provide the vitamin A capsules to be distributed.

The strategy also includes a training component to encourage consumption of locally available foods rich in vitamin A.
Possible opportunities exist to partner with other projects in the zone to accomplish this.

5c.17 The project manager (Jean-Pierre Bembamba) will be responsible for the technical oversight of the vitamin A component. He can access technical assistance from Clement Bouyain, Nutritionist and Dori health project manager, when needed. Dr. Ahmed zayan, Headquarters health unit acting director, will visit the project at least once a year to provide technical assistance for improving the nutrition component, including vitamin A.

5c.18 The project will train 8 Save the Children health promoters ("animatrices") to carry out the majority of the work involved in the vitamin A component of the project, 26 traditional birth attendants will also be trained. Training for the animatrices will be 6 hours beginning in January 1993. The traditional birth attendants will have 10 hours of training beginning in January as well. Both groups will participate in retrainings during the course of the project. The work of the animatrices will be monitored by a supervisor, as well as the health coordinator of the project and the health information system technician. The animatrices will in turn supervise the work of the traditional birth attendants.

5c.19 Vitamin A administration will be recorded on the MOH growth monitoring card. (appendix 3) This is the card the project will use. Project documents, including the HIS will be used in case the card is lost. During the mass campaign, a special notebook will be used to record all the names of the children who will be given a vitamin A capsule. This is in addition to marking the growth monitoring card. All documentation costs are included in the HIS budget, and budget provisions have been made accordingly.

Growth Monitoring

5c.20 The project will have a growth monitoring component. Baseline data show that 72.1% of the children have a growth monitoring card, Only 39.3% of the children have been weighed during the last three months, and 38.5% of the mothers do not know what to do if the child is in the danger area, while 35.7% take the child to the health center.

5c.21 Growth monitoring in Sapone/Ipelce in 1991 showed 31% of children under 80% of standard weight-for-age, indicating that malnutrition is widespread (Save the Children growth monitoring records). GM is conducted at the health centers once every three months. Also 2 SC promoters are conducting GM activities in 16 villages, three times a year per village. Mothers are interested in attending the GM sessions.

5c.22 The MOH recommends 4 growth monitoring visits per year for all children under the age of 5. The type of scale used is Salter (pese-bebe portatif). The project will identify children who are moderately or severely malnourished and follow them through home visits. We estimate lo-15% of children are malnourished. The project will have monitored 3500 children under the age of 3 by the final evaluation.

5c.24 3500 children under three are eligible for growth monitoring. Breakdown by age group is in table A. 4 visits per child per year will be required to reach full coverage. High risk for growth monitoring is defined as children below the 80th percentile of weight for age.

5c.25 The growth monitoring/promotion component of project will focus on weight-for-age measurements and training of mothers to avoid or recognize and treat their children for malnourishment. Weighings will take place 4 times a year. The program will be phased over the 3 years of funding. Save the Children will be the primary organizer for the weighings, with assistance provided by the MOH. The program will cover 18 villages in the first year. In the second and third years a total of 26 villages will be covered each year.

Traditional holidays, funerals, market days, field work during the harvest, and low participation from weak mobilization are the main constraints to holding weighing sessions quarterly. The program is designed to plan weighings around these times of low availability of villagers. Weak mobilization will require advance planning and solid execution of mobilization in the more challenging villages.

See section D.2 for details on planned inputs, expected outputs, and expected outcomes for growth monitoring/promotion component of this project.

5c.26 The project will train 8 Save the Children health promoters ("promoters") to carry out the majority of the work involved in the growth monitoring/promotion component of the project. 52 volunteer community health agents and 26 traditional birth attendants will be trained to assist them in social mobilization and execution of the weighings. They will also serve as health resource personnel in each village. Training for the promoters will be 12 hours over two days beginning in December 1992. The village volunteer health agents will have 12 hours of training over three days. The main focus of the trainings will be theory, demonstration and practice of baby weighings, documentation, health and nutrition information, and monitoring and referral systems. All three groups will participate in annual retrainings over the course of the project. The quality of work of the promoters will be monitored by a supervisor, as well as the health coordinator of the project and the health information system technician, through field visits of the supervisor of the promoters at least twice per month. The promoters will in turn supervise the work of the volunteer community health agents.

5c.27 Responsibility of technical oversight of all growth monitoring/promotion activities will be shared by the project coordinator, the health information system technician, and the supervisor of the promoters.

5c.28 Enclosed is a copy of the health card that will be used to follow a child's growth. (Appendix 3) There is a growth chart located at the back. If a child's card is lost it will be

replaced and the child's roster will be used to update the missing information.

5c.29 Using the HIS described in section E, the health promotors will use their rosters to identify malnourished children, and those growth faltering. They will be visited on a monthly basis. The promotors will be assisted by the VHWs. During the home visit, the child will be weighed again, and a food demonstration session will be conducted.

5c.30 Mothers with malnourished children identified during the GM sessions will be grouped to participate in nutrition demonstration, and education sessions. Severely malnourished children will be closely monitored through monthly home visits.

D.5d - DIP for Care of Mothers

5d.l Most recent data on maternal mortality shows a rate of 810/100,000 for Burkina Faso. Most common causes of maternal mortality are unknown.

5d.2 72% of women do not use prenatal care. There are 4 maternities that give prenatal services. Distance between the centers and the villages discourages their use by the population. Chloroquine is available at the health center level but most women do not have the means to purchase the prophylactic dose. Also, problems of resupply emerge frequently. Vitamin A is not currently available. Iron and folic acid are available sometimes in the health centers and the villages, During pregnancy, no known food is avoided by women. Women are expected to eat food rich in protein and iron, and vegetables. 47% of women said during the baseline survey that they ate less than normal during their last pregnancy.

5d.3 90.8% of the mothers had a vaccination card. Of these, 89.0% had three or more TT vaccinations. 16.7% of mothers had 1 prenatal visit, 11.7% had two or more. 41.7% of the mothers interviewed knew that they should see a health worker at least three times during their pregnancy. 46.0% of the mothers declared that a pregnant women should eat food rich in iron and protein (eggs, fish, meat). 20.5% of the mothers knew that a pregnant woman should eat leafy green vegetables. 68.3% of the women declared they were assisted by a traditional birth attendant during their delivery, and 20.4% by a professional health worker.

Referral services are available. If a women reaches a health center that cannot handle her condition, she gets transferred to the national hospital. A vehicle is available, but the patient's family has to pay for the fuel. The cost is beyond the reach of many villagers. Transportation from the village to the health center is done with a cart. All TBAs have received training, and have small delivery kits, Equipment and the skills of the personnel at the health centers and hospital are adequate.

5d.4 There is not any postnatal care available in the project area.

5d.5 Concerning family planning, 68.6% of the mothers interviewed declared they did not want a child in the next two years. 11.3 % of all women are using a contraceptive method. Among these women, 22.2% are using the pill, 14.8% are using condoms, and 14.8% are using other modern methods. 48.1% are using abstinence.

5d.6 During each year of the project it is estimated that 1,300 women will become pregnant with a total of 3,900 pregnancies during the project life. The breakdown by age group is in Table A. High risk pregnancy and birth factors are in appendix 5.

5d.7 Project objectives are: (1) 75% of high risk pregnancies will receive two prenatal and one postnatal visits, and will be assisted at delivery by a trained birth attendant who is

appropriately equipped; (2) 90% of women of child-bearing age will have received at least 2 doses of tetanus toxoïd; (3) 80% of TBAs and CHWs will be able to inform and refer families with respect to family planning techniques and AIDS prevention; (4) 50% of the population 10-49 years old will know at least one effective method of AIDS/STDs prevention; (5) 50% of couples will know how to procure and use at least one modem method of child spacing.

	Yr I	Yr II	Yr III
# of villages with trained TBAs	18	26	26
# of women receiving Prenatal care	250	600	975
# of couples trained in child spacing	750	1250	1250
# of people trained in AIDS prevention	1500	2500	2500

5d.8 The project's maternal health component will include:
pre- and Post-natal care, maternal nutrition, and support for evaluation services. For prenatal care, the project's nurse/midwives, the promoters, and the TBAs will contact village leaders and women's groups to inform them about prenatal care, child spacing, and AIDS/STD prevention. Every promoter will then identify pregnant women in their corresponding villages. The nurse/midwife will follow by visiting each village at least once every 2 months to conduct prenatal and postnatal visits. During the visit, the nurse/midwife will engage the TBAs in a continuing education process to improve their skills. TBAs will be responsible for giving iron and folic acid tablets. Supervision of the TBAs and their supplies and equipment will be the responsibility of the nurse/midwives, and the maternities' staff. The resupply for TBAs will be assumed by the medical center. The nurse/midwives will conduct group discussion sessions on maternal nutrition. The same messages will be reinforced during the consultation, and later on by the promoter through home visits. Detected high risk cases will be identified, and followed more regularly by the TBAs, and the promoters, The nurse/midwife will work with community leaders, VHCs, and women's groups to establish an evaluation system.

Family planning messages will be promoted during pre- and Post-natal visits, women's group meetings, and health education sessions. The health workers will organise group discussions among men to promote the use of family planning services. The project will establish a community based distribution system. VHWs and TBAs will sell the contraceptives for a margin of profits that they will keep. Condoms and spermicides will be available. Other methods like the pill will be discussed first with the MOH for their approval before making it available to the CBD program. Monitoring of family planning activities will be the responsibility of the nurse/midwife. Supplies will be provided by the health facilities.

AIDS and STD prevention messages will be promoted through (1) health education sessions, women's group discussions, and home visits; (2) increasing condom availability and accessibility; (3) increasing men's and adolescent's involvement in these discussions; and (4) training of trainers. The project is also planning to conduct a KAP study to identify the risk factors.

5d.9 Section D.2 covers planned inputs, expected outputs and outcomes for maternal care. Activities will begin in 18 villages first, then will be expanded to the remaining villages. The contraints include the long distance between the village and the health centers, low economic level, low education level, lack of methods of child spacing, and frequent interruption of chloroquine, iron, and folic acid supplies at the village level. Solutions planned by the project include establishment of an evaluation system, increased dialogue with the health center, and other SC sectors such as credit and agriculture to coordinate activities, conduct a literacy program for women, institute a community based distribution system of contraceptives, Provide information and promotion of contrceptive use, and support regular resupply system; of the medical center.

5d.10 The MOH health card is in appendix 6. This is the card the project will use. SC HIS will be used as a reference in case the maternal health card is lost.

5d. 11 The project intends to train at least 26 TBAs. Maternity staff and other potential referral personnel will be trained if needed. Also, the project will train the 228 family representatives, 52 VHWs, and 8 promoters on their role in maternal-health. The project's 2 nurse midwives, and the maternity staff will be supervising the maternal health activities of the project.

5d. 12 Same as question 5d. 11

5d.13 messages for the promotion of maternal health will include: (1) Advantage of the pre and postnatal visits. This includes: come early, and every 3 months; go to the postnatal visit 6 months after delivery; get help during delivery by a trained person; go to the health center if you have a high risk pregnancy. (2) Nutrition: Eat enough of available good food. (3) Birth spacing: It is better to wait for 2 years between births; here are the family planning methods and how to get them. (4) AIDS/STDs: These diseases are sexually transmitted; they can be prevented by abstinence, fidelity, one partner, and changing sexual behavior. Both men and women will receive messages on promotion of child spacing.

5d. 14 The project will work with the MOH to ensure the availability of maternal health component materials, supplies at the maternities, and with the TBAs. Maternal cards, and mass media educational material have been already developed by the MOH. If supplies are low, the project will use its funds to duplicate the materiels. Budget provisions have been made accordingly.

5d. 15 The two nurse/midwives (Aissatou Thiombiano & Fadima Idrissa Maiga) will be responsible for the technical oversight of the maternal care and family planning components. Job descriptions are in appendix 8.

D.5e - DIP for Case Management of Childhood Acute Lower Respiratory Infections/Pneumonia (ALRI)
(Non Applicable to this project)

D.5f - DIP for Control of Malaria

5f.l According to MOH analysis of its service statistics, Malaria is responsible for 20% of the mortality, and 28% of the morbidity rates. The average number of Malaria episodes per child per year is 6-8. Mothers do consider malaria a major problem for children and women.

Sf.2 Chloroquine is available in all health facilities. Availability is maintained by the MOH drug supply and distribution structure. The tablets are also available in private pharmacies. Although it is illegal to sell pharmaceutics on the open market, Chloroquine can be found with vendors, especially in the villages. 10-15 % of diagnosed malarial cases are caused by Plasmodium Falciparum, which is resistant to chloroquine treatment.

5f.3 No biomedical data was collected during the survey.

5f.4 Chloroquine is available. Traditionally, however, mothers used infusions made by boiling different herbs in water. No reported harm is caused by these solutions.

5f.5 All the population is eligible for Malaria prevention. In the project, the main target will

be children under five and women of child-bearing age. High risks include pregnant and lactating women, and children under 2 years of age.

5f.6 The objective of the Malaria Control component is 80% (21) of CHWs will be able to inform and refer families with respect to prevention and treatment of malaria.

5f.7 MOH policy focus on both prevention and treatment. Pregnant women receive a weekly dose of 300 mg of Chloroquine. The treatment consists of daily dose.600 mg. of chloroquine for 2 days followed by 300 mg. per day for 3 days. If condition persists, a diagnostic test for Plasmodium Falciparum is used to decide whether to give Fansidar or not. Severe cases are admitted in the hospitals and are given Quinimax intravenously. The project will follow the MOH policy, participate in the implementation of the national malaria strategy in the project area, and provide feedback information from the HIS to the MOH and the communities.

5f.8 The project will train families and committees in destruction of mosquito breeding sites; train CHWs to use chloroqume properly for treatment of fevers, and to manage chloroquine stocks; train families in proper malaria prophylaxes and treatment. Through credit funds provided under other funding, test (and possibly disseminate) local treatment and use of treated curtains and bednets; promote productron of Impregnated mosquito curtain/nets among women's income generating groups. Despite sporadic shortage, there is an adequate supply of antimalarial drugs in the project area. Since the distribution of chloroquine is illegal outside the health system, the project will not be able to train non-health groups in the diagnosis, and proper treatment of Malaria. For hospital management, Quinimax is given intravenously for severe cases. Fansidar is given to cases with chloroqume resistant malaria. This is in addition to the treatment of associated symptoms.

5f.9 The project will teach women the complications of malaria and how to treat it with chloroquine. Teaching materials will include posters, flashcards, and flanelograph (GRAAP - Groupe de Recherche et d'Appui pour l'Autopromotion Paysanne).

5f.10 The project will promote the referral of cases of malaria and diarrhea to a health facility. If this is not accessible, both conditions will be treated simultaneously with chloroquine and ORT.

5f. 11 Malaria is endemic in the project area. 20% of mortalities and 28% of morbidities are caused by Malaria.

5f.12 No malaria project is operating in the impact area. People who have used impregnated curtains are satisfied with the results. Bed nets are expensive, and are not commonly used by the population in the villages.

5f.13 The project will test the use of impregnated curtains/nets in a few areas. If the experience is favorable, expansion will be through women's groups engaged in economic development activities. See question 5f.8.

5f.14 Sustainability will be addressed through the use of income generation groups to produce and treat the bednets/curtains. The project's promotion approach will create the demands for the bednets/curtains. All needed materials are available on the market. The national malaria project (MOH) will be responsible for re-treatment.

5f.15 Messages for the Malaria component will be developed by the national malaria workshop in an upcoming workshop. Messages will be promoted through health education sessions organized in the health centers and the villages, village meetings, and women's groups. Other messages include covering stagnant water, fumigate the house with

malodoreous plants, and use a cover while sleeping.

5f. 16 Measures to ensure that the bednets reach the target population include local production, reasonable cost, availability and accessibility to the public, and create a demand for it among the project's target population.

5f. 17 Contraints include cost of the bednets/curtains and their re-treatment. The project will work with the income generation group to control cost, and will make sure that the re-treatment is available at the village level (still through the income generation groups) if the national program does not reach the impact area.

5f. 18 Project Coordinator (Jean-Pierre Bembamba) will be responsible for technical oversight of the project malaria component. Ahmed Zayan, M.D., M.P.H. (Headquarters Health Unit) will provide technical assistance when requested by the project coordinator or the field office director.

D.5g - DIP for Other Project Interventions (Not Applicable to this project)

SECTION E. **Project Health Information System**

E.l The project has allocated enough resources to cover the cost of the 100% family enrollment (described below) and hired an HIS coordinator (Gaston Sobgo), and will hire a data entry clerk to maintain the project HIS. They will work very closely with project staff to ensure proper collection and analysis of data. The overall coordination will be the responsibility of the project manager (Jean-Pierre Bembamba). Needed equipment and supplies include a computer, a printer, a large amount of printed materials, and a few related supplies such as pens, kerosene, etc. Over the life of the project, $23,150 will be spent on baseline survey, midterm and final evaluation; $8,000 for DIP and annual reports; $36,000 for family enrollment, and other components of the HIS; $7,500 for a computer and its accessories to be used for program management. This totals $74,650, approximately 8.4% of the total project budget.

Technical assistance needed to develop the HIS will be provided by SC Headquarters based health unit (Dr. Ahmed Zayan), and the Mali Field Office (Dr. Fode Doumbia). The HIS consultant will be required for approximately two weeks to help design the baseline survey. One TA visit from Save the Children HQ staff will be needed for design and quality control of the family registration, Costs for headquarters technical assistance visits are included in the HO budget under international travel and per diems. The JHU CS support group will be contacted to provide assistance as needed with the baseline, MTE, and final evaluation. SC/BF has access to extensive consultant databases; it will give priority to Burkinabes and other West Africans. The following is an approximate schedule of TA visits needed by the Project: Family enrollment (12/92-2/93) for area I and (12/93-2/94) for area II; Baseline survey completed (2/93); DIP completed (4/93); Rosters will be updated on an ongoing basis. Monitoring system completed (4/93); Internal monitoring reports (Monthly); External monitoring reports (Quarterly); Annual Reports (9/93, 9/94); Midterm Evaluation (4194); Final Evaluation (9/95). The HIS will be fully operational by April 1993.

E.2 The complete census will be a part of the 100% family enrollment. This will be carried out first in 18 villages in the first year, and 8 villages in the second year. Workers involved in the family enrollment include the HIS coordinator, 1 supervisor, 8 promoters, 26 surveyers. The census should be completed *in* 2 months, including tabulation, and development of rosters. The system will be used on a daily basis to conduct project activities, and will be updated once every two months through vital events reports (birth, death, and migration).

100% family registration will be carried out. It is designed to keep track of a range of village population statistics from basic census records to personal health records. Following the family registration, each family in the district will have an enrollment card; basic and health information from the enrollment is used to create women's and children's rosters kept and used by the promoters. Rosters contain data on immunization, growth monitoring, ORT training, pregnancy, etc. Demographic and health information will be updated on an ongoing basis through home visits assisted by village health committees. The HIS is used to ensure that each member of the community receives appropriate health services. Data are also used for planning and decision making. While the HIS employs manual methods at the village level, reporting at all other levels is incorporated into a computerized system which aggregates and analyzes the detailed village data and prepares reports to suit the needs of the users.

F.1.

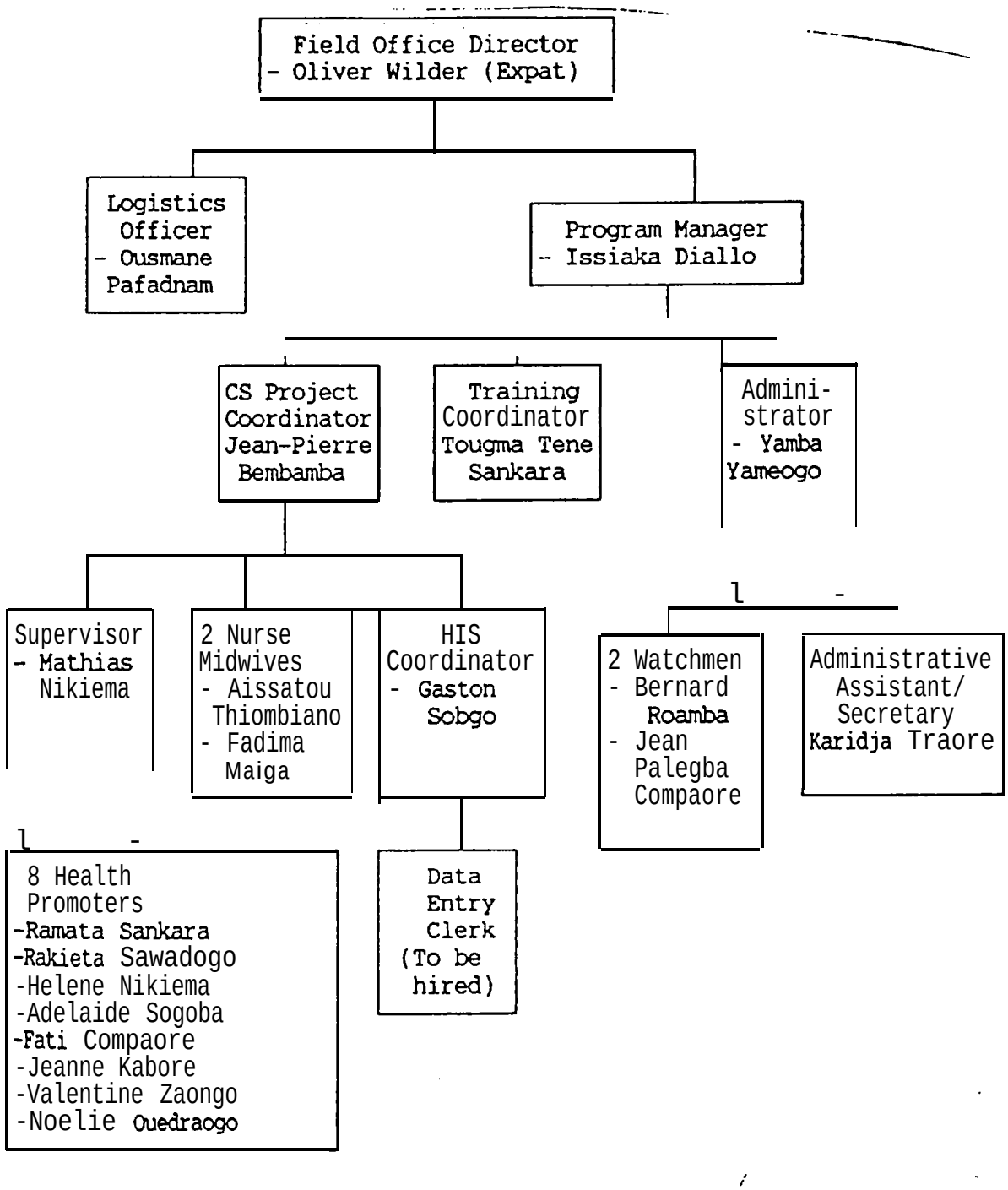
E.3 Census data! service statistics, and data on project interventions will be collected. Except for service statisbcs, data will be collected on a daily basis, and added to the computerized data base every two months for every promoter. The HIS coordinator will be responsible for tabulation and analysis, and generation of reports. The promoters will be under constant supervision by their supervisor, the HIS coordinator, and the project manager. They will not only verify the promoters record, but also conduct home visits to check the roster's data on home records. The computerized HIS has cross checking capabilities that allow the user to reduce entry of wrong data. Results of monitoring reports and midterm and final evaluations will be released to all interested parties i.e. communities, MOH, HO, and donors.

E.4 Data analysis training is provided on a continuous basis to those responsible for tabulating, analysing, and using the data. The HIS coordinator has a formal training in data collection and analysis. He worked on the national EPI program for 3 years on coverage surveys, operational evaluation, and KAP surveys. The 8 promoters, and the supervisor will be trained by him, the FOD, and during TA visits from SC Headquarters health unit. The following is a description of the data collection and management system: Data analysis and the overall management of the health information system will be primarily the responsibility of the Information Systems Coordinator, under the supervision of the project manager. Promoters, VHCs, and VHWs will collect ongoing data in the rosters. Promoters compile the data into monthly reports which they discuss with VHCs. They will then pass the data to the HIS Coordinator in Sapone, who checks data validity and supervises its entry in the computer. Regular computer reports are generated, and cross-checked with promoter reports and rosters for accuracy. HIS Coordinator's reports to Promoters provide the latter with timely, actionable feedback for further discussion with VHCs. The MOH staff will participate with SC in the process to monitor and target its activities.

E.5 The MOH participated in the implementation of the baseline survey. Community groups' participation was manifested in their willingness to allow the survey teams to visit the village. The baseline survey interviewed 240 women with a child under 2 and took 4 days in the field to collect the data. 10 surveyers, 5 supervisors, and 4 facilitators participated in the implementation of the survey. The approximate cost of the survey was $3,500,

SECTION F. Human Resources

F.1. Following is an organizational chart showing the positions in the project:



All personnel are locally hired, with the exception of the Field Office Director; and all personnel are full-time and salaried staff members.

F.2. The persons responsible for liaison with community groups and women's groups are: the 8 health promoters, the promoter supervisor, the two nurse-midwives, and the training coordinator. There will be 26 village associations (Groupements Villageois) involved with the project, each of which meets at least 12 times a year. Smaller women's groups of various types will be included as the opportunity arises, and cannot be quantified at this time.

F.3. A total of approximately 50 community health workers will take part in this project. With a total potential beneficiary population of about 18,637, this is about one CHW per 373 potential beneficiaries. The CHWs will be supervised directly by 10 project staff (two nurse/midwives and eight promoters), giving a ratio of one to five.

F.4. Turnover of trained health volunteers in the project area is historically quite low. Very few CHWs have left their positions in the recent past. Obtaining new CHWs to replace those who leave is likely to be a one- or two-time task during the life of the project.

F.5. Incentives offered to motivate good job performance and continuation include: recognition of status and role within the community; profits on sales of condoms, chloroquine and other appropriate items; opportunities for training and study visits.

F.6. Each CHW will have the opportunity to participate in two to five refresher trainings each year, in collaboration with MOH personnel. The Provincial Health Directorate has already collaborated with SC/US on these trainings under other funding in past years, and this collaboration will continue. Project staff will receive one major refresher training in September or October of each year, with short monthly or bi-monthly refresher sessions focussing on upcoming project activities. Staff training will mainly be carried out by the Project Coordinator and other staff, with some participation by MOH staff.

F.7. The only non-national staff member associated with the project is the SC/US Field Office Director. All staff based in the project area are nationals, and they will be directly responsible for managing the project. Senior project staff are already trained in planning, budgeting, accounting, personnel management, and financial management, and further trainings will be held in these areas at least once a year. Computer use will be encouraged through installation of SC/US's ProMIS computerized information system, with associated training. Project staff will, as in the past, be asked to contribute to the process of generating future and/or complementary funding for project activities; this may mean both proposal development and making contacts with potential funders.

F.8. Dr. Ahmed Zayan, Acting Director - Primary Health Care, will be responsible for technical backstopping of this project at SC/US headquarters. At least one visit will be made to the project per year, consisting of at least ten days per visit. The purposes of the visit will include: program planning, monitoring, and evaluation; health information system trouble-shooting; and contacts with project partners (MOH and others).

SECTION G. Management and Logistics

G.1. Community health workers will cover their villages on foot. Front-line project staff will each use a Yamaha V80 motorcycle to travel from village to village. There are sufficient numbers of these motorcycles now in place. These motorcycles will be gradually sold to staff through a hire/purchase scheme, and each staff member will be responsible for a percentage of repair and maintenance costs for his/her motorcycle. In

a continuation of a system that has worked well in the past, repair and maintenance will be contracted out to local mechanics. Each staff member will also receive a monthly fuel allocation, calculated on the basis of a monthly work plan.

A Toyota double cabin pickup truck has also been acquired for complementary transport needs. At this time, only the-official driver and the program manager are authorized to drive the vehicle. Other drivers may be authorized based on need, credentials and a driving skills test. The pickup truck will only be used in cases where use of motorcycles is inefficient or impossible,

The costs of the motorcycles and pickup truck are reflected in the budget under equipment procurement and under other direct costs.

6.2. Supplies and equipment that still need to be obtained are as follows:

To be ordered from local printer:
- health information system forms;
- health booklets (including growth monitoring charts and other relevant information) for children and pregnant women.

To be acquired from the Ministry of Health:
- nutrition promotion flipcharts;
- Vitamin A capsules (provided by UNICEF free of charge).

To be ordered from other sources:
- GRAAP health promotion materials;
- office supplies.

Other supplies and light equipment may be ordered when a particular need is encountered. For example, if the condom supply network run by the MOH is not effective in providing a continuous re-supply of condoms to village health workers, the project may order condoms from other sources.

All supplies will be transported from Ouagadougou to the project site using the project's pickup truck.

TABLE B: COUNTRY PROJECT SCHEDULE OF ACTIVITIES

(Check box to specify Quarter and Year)

PVO: Save the Children
Country: BURKINA FASO

	Year 1				Year 2				Year 3		
	1	2	3	4	1	2	3	4	1	2	3
1. Personnel in Position											
a. Project Manager	X	X	X	X	X	X	X	X	X	X	X
b. Technical Coordinator	X	X	X	X	X	X	X	X	X	X	X
c. Health Information System Manager	X	X	X	X	X	X	X	X	X	X	X
d. Community/Village health workers	X	X	X	X	X	X	X	X	X	X	X
e. Other Support	X	X	X	X	X	X	X	X	X	X	X
2. Detailed Implementation Plan											
a. Design/Planning	X										
b. Preparation of DIP	X										
3. Health Information System											
a. Baseline Survey											
- Design/preparation	X										
- Data collection and analysis	x										
- Dissemination and feedback to community and project management	x										
b. Consultants/Contract to design HIS	X										
c. Develop and test HIS											
- Implementation		x	x	x	X	X	X	X	X	X	X
- Development and feedback to community and project management			x	x	X	X	X	X	X	X	X
4. Training											
a. Design		x	x					X			
b. Training of trainers		x	x					X			
c. Training sessions		x	x					X			
d. Evaluation of knowledge and skills	X			X			X		X		
5. Procurement of Supplies		x	x				x				x
6. Service Delivery to be initiated											
a. Area 1: Sapone/Ipelce/Doulougou 18 villages											
- ORT			x	x	X	X	X	X	X	X	X
- Immunization		x	x	X	X	X	X	X	X	X	X
- Nutrition											
Breastfeeding			X	X	X	X	X	X	X	X	X
Maternal Nutrition				X	X	X	X	X	X	X	X
Vitamin A			X		X		X		X		X
Growth Monitoring/Promotion			X	X	X	X	X	X	X	X	X
- ALRI/Pneumonia											
- Family Planning/Maternal Care			X	X	X	X	X	X	X	X	X
- Other: Malaria/Vit. A/AIDS			X	X	X	X	X	X	X	X	X

TABLE B: COUNTRY PROJECT SCHEDULE OF ACTIVITIES

PVO: Save the Children Country: BURKINA FASO	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
b. Area 2:												
Sapone/Ipelce/Doulougou 8 villages												
– ORT					X	X	X	X	X	X	X	X
– Immunization		X	X	X	X	X	X	X	X	X	X	X
– Nutrition												
Breastfeeding					X	X	X	X	X	X	X	X
Maternal Nutrition					X	X	X	X	X	X	X	X
Vitamin A					X		X		X		X	
Growth Monitoring/Promotion					X	X	X	X	X	X	X	X
– ALRI/Pneumonia												
- Family Planning/Maternal Care					x	x	x	x	x	x	x	x
- Other: Malaria/Vit. A/AIDS					x	x	x	x	x	x	x	x
7. Technical Assistance												
a. HQ/HO/Regional office visits	X	X			X		X			X		X
b. Local Consultants		X		X			X					
c. External technical assistance	X						X					
8. Progress report												
a. Annual project reviews			X				X				X	
b. Annual reports				X				X				X
c. Mid–term evaluation							X					
d. Final evaluation												X

PVO/COUNTRY: Save the Children Burkina Faso	Year 1 (a) A.I.D.	Year 1 (b) PVO	Year 2 (c) A.I.D.	Year 2 (d) PVO	Year 3 (e) A.I.D.	Year 3 (f) PVO	TOTAL – Years 1–3 (g) A.I.D.	TOTAL – Years 1–3 (h) PVO	TOTAL – Years 1–3 (i) TOTAL
1. PROCUREMENT									
A. Office Equipment (specify)									
1. Office	0	47,500	0	0	0	0	0	47,500	47,500
2. EPI	0	0	0	0	0	0	0	0	0
3. ORT	0	0	0	0	0	0	0	0	0
4. Other	0	0	0	0	0	0	0	0	0
Subtotal	0	47,500	0	0	0	0	0	47,500	47,500
B. Supplies									
1. Office	3,500	1,000	3,500	1,000	3,500	1,000	10,500	3,000	13,500
2. EPI	1,000	0	1,000	0	1,000	0	3,000	0	3,000
3. ORT	0	0	0	0	0	0	0	0	0
4. Other	10,000	5,000	500	5,000	0	5,000	10,500	15,000	25,500
Subtotal	14,500	6,000	5,000	6,000	4,500	6,000	24,000	18,000	42,000
C. Consultants (exclude evaluation costs)									
1. Local	1,000	2,000	1,000	2,000	1,000	2,000	3,000	6,000	9,000
2. External	0	0	0	0	0	0	0	0	0
Subtotal	1,000	2,000	1,000	2,000	1,000	2,000	3,000	6,000	9,000
D. Services (exclude evaluation costs)									
1. Manpower Services	1,500	0	1,500	0	1,500	0	4,500	0	4,500
2. Lectures/Talent Fees	0	0	0	0	0	0	0	0	0
3. General Contractual Services	0	0	0	0	0	0	0	0	0
Subtotal	1,500	0	1,500	0	1,500	0	4,500	0	4,500
PROCUREMENT SUBTOTAL	17,000	55,500	7,500	8,000	7,000	8,000	31,500	71,500	103,000

DIP TABLE C: COUNTRY PROJECT BUDGET

Place dollar amounts in shaded areas only

PVO/COUNTRY: Save the Children Burkina Faso	Year 1 (a) A.I.D.	Year 1 (b) PVO	Year 2 (c) A.I.D.	Year 2 (d) PVO	Year 3 (e) A.I.D.	Year 3 (f) PVO	TOTAL – Years 1–3 (g) A.I.D.	TOTAL – Years 1–3 (h) PVO	TOTAL – Years 1–3 (i) TOTAL
II. EVALUATION (specify)									
A. Baseline Survey									
1. Consultant/Contract	0	0	0	0	0	0	0	0	0
2. Staff Support	1,800	0	0	0	0	0	1,800	0	1,800
3. Other (+ Travel)	1,750	0	0	0	0	0	1,750	0	1,750
Subtotal	3,550						3,550		3,550
B. Mid-term									
1. Consultant/Contract	0	0	8,100	0	0	0	8,100	0	8,100
2. Staff Support	0	0	1,000	0	0	0	1,000	0	1,000
3. Other (+ Travel)	0	0	6,500	0	0	0	6,500	0	6,500
Subtotal	0	0	15,600	0	0	0	15,600	0	15,600
C. Final Evaluation									
1. Consultant/Contract	0	0	0	0	0	0	0	0	0
2. Staff Support	0	0	0	0	1,000	0	1,000	0	1,000
3. Other (+ Travel)	0	0	0	0	3,000	0	3,000	0	3,000
Subtotal	0	0	0	0	4,000	0	4,000	0	4,000
EVALUATION SUBTOTAL	3,550	0	15,600	0	4,000	0	23,150	0	23,150
III. PERSONNEL									
A. Technical	96,107	0	100,912	0	105,989	0	303,008	0	303,008
B. Administration	11,167	23,478	11,725	24,652	12,312	25,884	35,204	74,014	109,218
C. Clerical	6,768	0	7,106	0	7,462	0	21,336	0	21,336
D. Temporary	1,000	0	1,000	0	1,000	0	3,000	0	3,000
PERSONNEL SUBTOTAL	115,042	23,478	120,744	24,652	126,762	25,884	362,548	74,014	436,563

BUDGET (Field + HQ)

Place dollar amounts in shaded areas only

PAGE 1 OF 3

PVO/COUNTRY: Save ...

Year 1

PVO/COUNTRY: Save the Children Burkina Faso	Year 1 (a) A.I.D.	Year 1 (b) PVO	Year 2 (c) A.I.D.	Year 2 (d) PVO	Year 3 (e) A.I.D.	Year 3 (f) PVO	TOTAL – Years 1–3 (g) A.I.D.	TOTAL – Years 1–3 (h) PVO	TOTAL – Years 1–3 (i) TOTAL
IV. TRAVEL/PER DIEM									
A. Domestic	6,800	2,000	6,800	2,000	6,800	2,000	20,400	6,000	26,400
B. International	6,800	0	7,000	0	6,900	0	20,700	0	20,700
TRAVEL/PER DIEM SUBTOTAL	13,600	2,000	13,800	2,000	13,700	2,000	41,100	6,000	47,100
V. COMMUNICATIONS									
A. Printing/Reproduction	9,000	0	3,000	0	3,000	0	15,000	0	15,000
B. Postage/Delivery system	1,000	1,000	1,000	1,000	1,000	1,000	3,000	3,000	6,000
C. Telephone	500	1,500	500	500	500	500	1,500	2,500	4,000
D.FAX/Telex	500	500	500	500	500	500	1,500	1,500	3,000
COMMUNICATIONS SUBTOTAL	11,000	3,000	5,000	2,000	5,000	2,000	21,000	7,000	28,000
VI. FACILITIES									
A. Equipment Rentals	0	0	0	0	0	0	0	0	0
B. Facilities Rentals	1,000	2,000	1,000	2,000	1,000	2,000	3,000	6,000	9,000
C. Other	0	0	0	0	0	0	0	0	0
FACILITIES SUBTOTAL	1,000	2,000	1,000	2,000	1,000	2,000	3,000	6,000	9,000
VII. OTHER DIRECT COSTS	22200	19000	22700	19000	25200	19014	70,100	57,014	127,114
OTHER DIRECT COSTS SUBTOTAL	22,200	19,000	22,700	19,000	25,200	19,014	70,100	57,014	127,114
VIII. INDIRECT COSTS									
A. Overhead/Administration	37,229	0	37,828	0	37,080	0	112,137	0	112,137
B. Other									
INDIRECT COSTS SUBTOTAL	37,229	0	37,828	0	37,080	0	112,137	0	112,137
TOTAL PROJECT COST	220,621	104,978	224,172	57,652	219,743	58,898	664,535	221,528	886,064

STAFF SALARIES Save the Children/Burkina Faso POSITION	YEAR ONE (92-93) #	Salaries	Benefiis	TOTAL	YEAR TWO (93-94) #	Salaries	Benefits	TOTAL	YEAR THREE (94-95) #	Salaries	Benefits	TOTAL	TOTAL
Project Coordinator	1	8,880	3,641	12,521	1	9,324	3,823	13,147	1	9,790	4,014	13,804	39,472
Coord, Info Systems	1	5,760	2,362	8,122	1	6,048	2,480	8,528	1	6,350	2,604	8,954	25,603
Training Coordinator	1	7,680	3,149	10,829	1	8,064	3,306	11,370	1	8,467	3,472	11,939	34,138
Nurse/Midwife	2	5,760	2,362	16,243	2	6,048	2,489	17,055	2	6,350	2,604	17,908	51,207
Promoter Supervisor	1	5,760	2,362	8,122	1	6,048	2,480	8,528	1	6,359	2,604	8,954	25,603
Promoters	8	3,120	1,279	35,194	8	3,276	1,343	36,953	8	3,440	1,410	38,801	110,948
Field Office Director (25%)	1	8,750	2,188	10,938	1	9,188	2,297	11,484	1	9,647	2,412	12,059	34,480
Impact Area Manager (50%)	1	6,000	2,460	8,460	1	6,300	2,583	8,883	1	6,615	2,712	9,327	26,670
Logistics Officer (25%)	1	1,200	492	1,692	1	1,260	517	1,777	1	1,323	542	1,865	5,334
Administrator	1	6,240	2,558	8,798	1	6,552	2,686	9,238	1	6,880	2,821	9,700	27,737
Bookkeeper	1	4,800	1,968	6,768	1	5,040	2,066	7,106	1	5,292	2,170	7,462	21,336
Watchmen	2	1,680	689	4,738	2	1,764	723	4,974	2	1,852	759	5,223	14,935
Secretary/Data Entry Clerk	1	3,600	1,476	5,076	1	3,780	1,550	5,330	1	3,969	1,627	5,596	16,002
Temporary	1	1,000	0	1,000	1	1,000	0	1,000	1	1,000	0	1,000	3,000
TOTAL	23			138,499	23			145,374	23			152,593	436,466

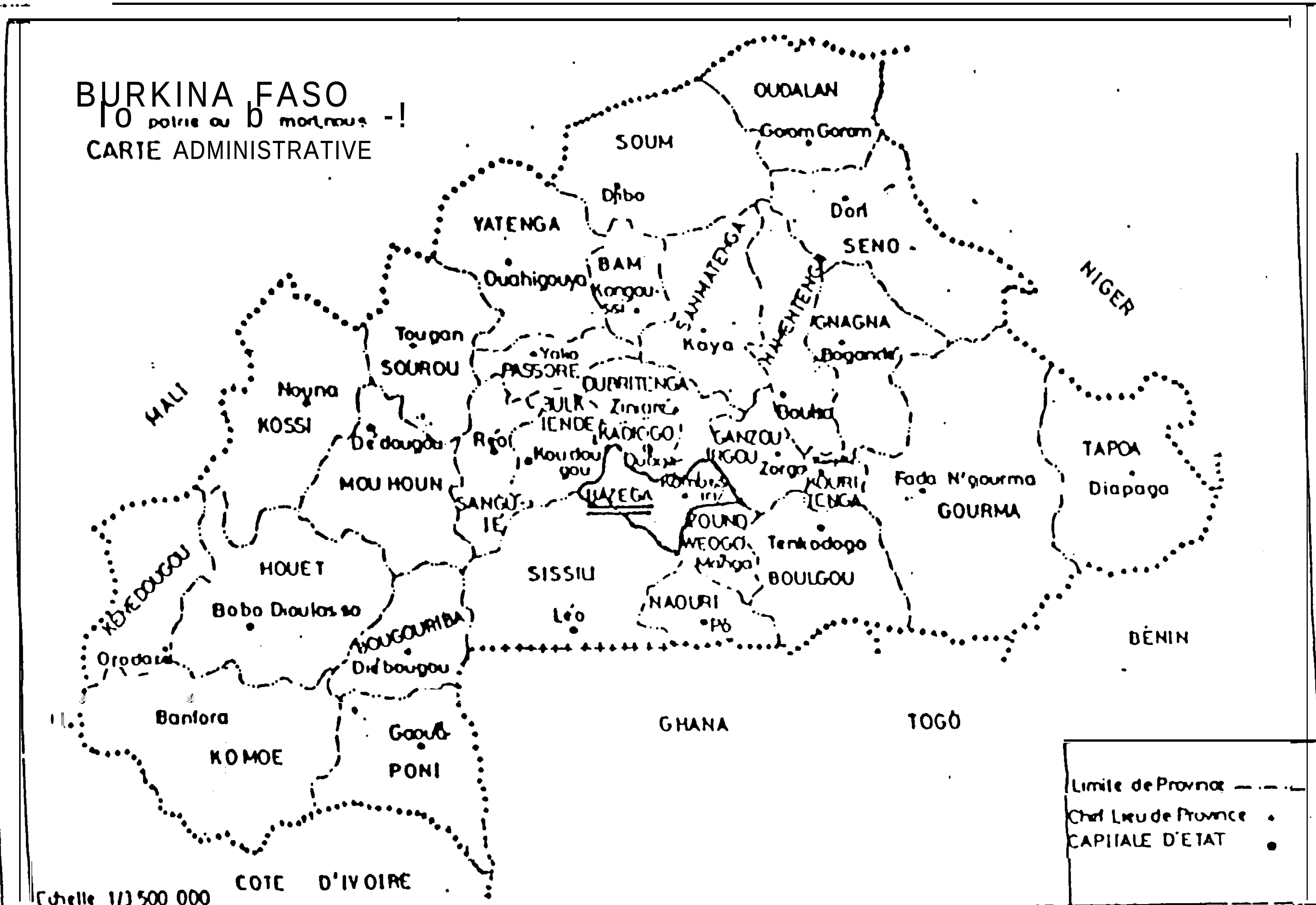
CAPITAL ASSETS	Amount
Computer system for ProMIS	4,500
Toyota Double Cabin Pickup	25,000
12 Yamaha 80 Motorcycles	18,000
Total	47,500

A.I.D. Contribution	362,514
P.V.O. Contribution	73,952

PVO/COUNTRY: Save the Children

Year 1		Year 2		Year 3		TOTAL - Years 1–3		
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)

Appendix 1.


BURKINA FASO
CARTE ADMINISTRATIVE
MALI
NIGER
OUDALAN
Gorom Gorom
SOUM
Djibo
YATENGA
Ouahigouya
BAM
Kongoussi
SANMATENGA
Kaya
NAMENTENGA
SENO
Dori
GNAGNA
Bogande
Tougan
SOUROU
Yako
PASSORE
OUBRITENGA
Ziniare
KADIOGO
Ouagadougou
Boulsa
GANZOURGOU
Zorgo
KOURITENGA
Nouna
KOSSI
Dedougou
MOUHOUN
Reo
Koudougou
SANGUIE
BOULKIEMDE
BAZEGA
Kombissiri
Tenkodogo
Fada N'gourma
GOURMA
TAPOA
Diapaga
HOUET
Bobo Dioulasso
KENEDOUGOU
Orodara
SISSILI
Leo
NAOURI
Po
ZOUNDWEOGO
Manga
BOULGOU
BOUGOURIBA
Diebougou
BENIN
Banfora
KOMOE
Gaoua
PONI
GHANA
TOGO
COTE D'IVOIRE
Echelle 1/3 500 000
Limite de Province
Chef Lieu de Province
CAPITALE D'ETAT

Appendix 2.

Diarrheal Diseases Protocol - Condensed Translation

TO TREAT DIARRHEA

Explain the three rules for home treatment:

1. Give your child more liquids than usual to prevent dehydration.

2. Give your child solid foods.

3. Bring child to a health agent if the child shows signs of dehydration, is not eating/drinking normally, or is not getting better.

Show the mother how to use ORS at home:
- 50-100 ml ORS after each stool for children under 2 yrs.
- 100-200 ml ORS after each stool for children over 2 yrs.
- adults should drink as much as they want to.
- child should keep breastfeeding and/or eating and drinking while taking ORS.

Explain how the mother can prevent future diarrhea:
- exclusive breastfeeding, proper weaning, hygiene, etc.

TO TREAT DIARRHEA AT THE HEALTH CENTER

1. Give proper quantity of ORS according to weight.

2. If mother is present, show her how to continue ORS.

3. After 4-6 hours, assess child again and choose appropriate treatment plan.

4. If mother must leave before treatment has been completed, give her complete instructions and enough ORS packets for at least 2 more days.

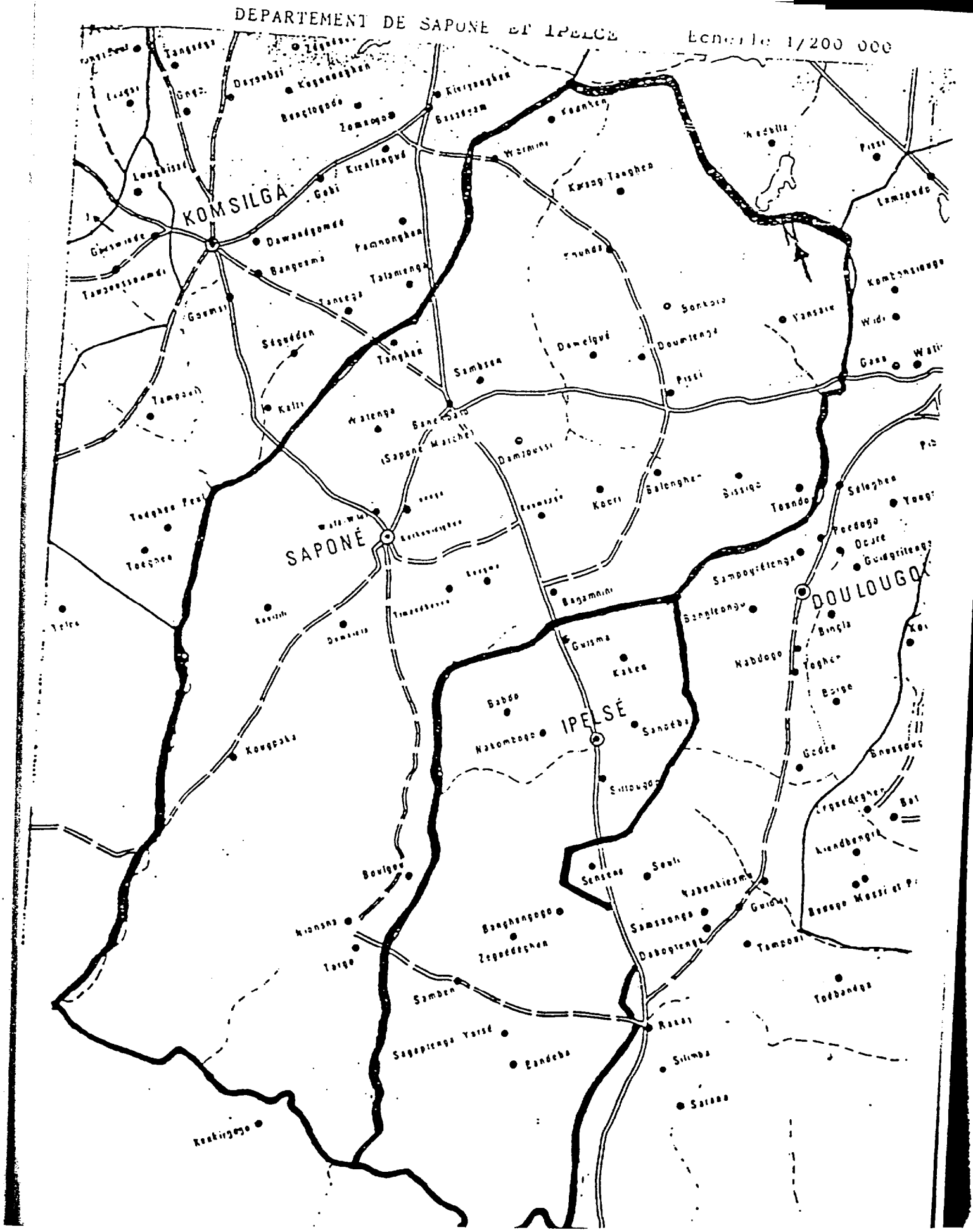
FOR SEVERE DEHYDRATION:

Can I.V. be administered? If yes, administer I.V. and begin ORS.

If no, can child drink? If yes, begin ORS, and send child to nearest center where I.V. is available.

If child cannot drink and I.V. is unavailable, perform rehydration via nasogastric tube.

If none of the above are possible, send child to nearest reference level where I.V. can be administered.


DEPARTEMENT DE SAPONE ET IPELCE
Echelle 1/200 000
KOMSILGA
SAPONE
IPELSE
DOULOUGOU

PLAN DE TRAITEMENT A

POUR TRAITER LA DIARRHEE

EXPLIQUER LES **TROIS** RECLES POUR TRAITER LA DIARRHEE A **DOMICILE**

1. Donner à votre enfant plus de **liquide que** d'habilude pour **prévenir la déshydratation :**

. Ler **solutions** i domicile nationalement recommandées ou
. **Les liquides** i base d'**aliments** tels quc bouillies, eau de riz
. Le **lait maternel** ou **le lait reconstitué préparé avec** 2 fois plus d'eau que d'habitude.

2. **Donner à votre enfant** des rlimenls solides .

. Donner der alimentr **récemment** prepares. **Les** alimentr **recommandés** sont les melanges de **céréales** et de legumineuses. ou bien de **céréales** avec viande ou **poisson. Ajoutez** quelques **gouttes** d'huile i **l'aliment si** possible.
. Donner der jus de hits ou des bananes pour *fournir* du **potassium.**
. **Donner** les **aliments** chaque 3 ou 4 heurcs (6 fois par **jour**) ou plus souvent pour les **très petits enfants.**
. Encourager l'enfant i **manger autant qu'il veut.**
. Cuire **et** Pcrascr ou mouiller bicn les **aliments** pour **faciliter** la **digestion.**
. *Après* la *diarrhée* donner un *repas* de plus chaque *jour* pendant une semaine. ou jusqu'i ce que **l'enfant récupère** son **poids** normal.

3. Amencr **l'enfant** chez l'agcnt de **santé** si l'enfant i un des elements **ci-dessous:**

. **Fajt** beaucoup de **selles**
. **A** très soil
. A **les veux enfoncés**
. A *une forte fièvre*

} cer trois signes font penser à une déshydratation.

• Ne mange pas ou ne **boit** pas **normalement**
. Semble ne pas s'ameliorer.

MONTRER A LA MERE COMMENT **UTILISER** UNE SOLUTION SRO A DOMICILE **SI**:

. *son enfant a été traité suivant* le plan B pour *prévenir* le *retour* de la *déshydratation*
. **si** la **politique** du pays **est** dc donner une **solution** SRO i **tous** les *enfants* amenés i un **centre** de **santé** pour y recevoir un **traitement** de la *diarrhée* ou
. la **mère** nc peut pas revenir au **centre si** la *diarrhée* empire.

Lui **montrer** comment **préparer** et adminislrer la **solution. Montrez-lui** combien **donner**

. 50 i 100 ml **(1/4** i **1/2** grande **tasse)** de solution SRO **après** chaque **selle** pour un **enfant** de **moins** de **deux** ans.
. 100 i 200 ml **(1/2** i 1 grande **tasse)** pour **un enfant** plus **âgé**
. ler **adultes doivent** boirc **autant qu'ils veulent.**

Dites-lui que si l'enfant vomit d'attendre 1 0 minutes avant de continuer à donner la solution mais *plus lentement – une cuillerée toutes les 2 à 3 minutes*

Lui donner **assez de sachets** pour deux **jours**

Remarque : Pendant que **l'enfant reçoit** la SRO, on **doit** lui donner du **lait maternel** ou du **lait dilué.** On *doit* lui proposer des **aliments.** Ni lcr **liquides** 6 **base** de **céréales** ni la **solution** eau. sel. **sucre** nc dcvraient **être donnés avec les sachets**

EXPLIQUER COMMENT ELLE PEUT PREVENIR LA DIARRHEE

. fn **donnant uniquement le lait maternel** pendant les premiers 4 6 6 mois et en continuant l'**allaitement** *pendant au moins* la *première année.*
• En **introduisant** dcs **aliments de sevrage** propres et *nutritifs à partir* de 4 6 6 moir.
. En donnant 6 wn **enfant les aliments** récemment préparés et **bien cuits ainsi** quc de **l'eau** potable.
. In faisant de sorte quc **tous** lcc **membres** de la famille **lavent** leurs mains aver du **savon** aprés avoir été i la **selle** et avant dr préparer ou de manger lrs **aliments.**
. fn faisant de sorte que tous les membres de la famille utilisent une latrine.
. fn se débarrassant rapidement des selles du jeune enfant en les mettant dins une latrine ou en les enfouissant

PLAN DE TRAITEMENT B

POUR TRAITER LA DESHYDRATATION PAR SOLUTION SRO

1. QUANTITE DE SOLUTION A DONNER PENDANT LES 4 A 6 PREMIERES HEURES.

Age du patient'	2 4 6 8 10 12 18 mois — 2 3 4 6 8 15 année — adulte
Poids du patient en kilogrammes	3 5 7 9 71 13' 15 20 30 40 50

Administrer cette quantité de solution pendant 4 à 6 heures	en ml	200-400	400-600	600-800	800-1000	1000-2000	2000-400(
	en unité locale de mesure						

• Utilirez l'âge du patient seulement si vous ne connaissez pas son poids.

Remarqur: Encourrger la mere i continuer l'allaitement maternel

- Si le patient réclame plus de solution SRO. donnez-lui en plus.
- Si les paupieres gonflent, arrêter et donner d'autres boissons. Renouveler la SRO dès que les paupieres seront dégonflées, si la diarrhée continue.
- Si l'enfant vomit. attendez 10 minutes, puis poursuivez lentement et par petites quantités l'administration de la solution SRO.

2. SI LA MERE PEUT RESTER AU CENTRE DE SANTE

. Indiquez-lui la quantité de solution SRO à donner i son enfant
• Montrez-lui comment la lui donner - une cuillerée chaque minute ou deux
• Vérifiez de temps en temps pour voir s'il a des problèmes.

3. APRES 4 A 6'HEURES, FAITES UNE NOUVELLE EVALUATION DE L'ENFANT EN UTILISANT LE TABLEAU (COMMENT EVALUER VOTRE PATIENT) PUIS CHOISISSEZ LE PLAN DE TRAITEMENT APPROPRIE

Remarque: Si un enfant doit continuer le plan de traitement 6,
dites à la mère d'offrir de petites quantites de nourriture.

Si l'enfant a moins de 12 mois. dites à la mère dc donncr
. du fait maternel entre les prises de solution SRO. ou
. de 100 à 200 ml d'eau potable avant de poursuivre la solution SRO. au car où elle n'allaite pas son enfant.

4. SI LA MERE DOIT REPARTIR AVANT LA FIN DU PLAN DE TRAITEMENT B

• Donner-lui asscz de sachets SRO pour dcux jours et montrez-lui comment préparer la solution.
. Montrez-lui combien de SRO elle doit donner pour tcrminer i donricilc lc traitement des 4 à 6 heures.
. Diter-lui de donncr i l'enfant autant de solution SRO (et d'autres liquides) qu'il voudra après la fin des 4 à 6 heures de trait cnrcnt .
. Dites-lui d'offrir à l'enfant les petites quantités dc nourriture chaquc 3 à 4 hcurcs.
. Dites-lui de ramener l'enfant au centre d c santë si l'enfant a un des éléments ci-dessous :

- Fail beaucoup de selles
- A très soil — ccs trois signes font pcnscr à une
- A les yeux enfoncés — déshydratation
- A une forte fièvre
- Ne mange pas ou ne boit pas normalement
- Semble ne pas s'améliorer.

PLAN DE TRAITEMENT C

POUR TRAITER RAPIDEMENT UNE DESHYDRATATION GRAVE

• Suivez les flèches. Si la réponse à la question est • oui », lisez à droite. Si c'est • non • , lisez plus bas.

COMMENCEZ ICI

Etes-vous en mesure d'administrer une perfusion intraveineuse (IV) ?

OUI →

1. Administrer la perfusion IV (de préférence k Ringer Lactate). Note : si l'enfant peut tie. donner la SRO jusqu'au commencement dc la perfusion.
2. Après 3 heures arrêter la perfusion et commencer h SRO.
3. Après 1 à 3 heures ou plus réévaluer l'enfant et choisir le plan de traitement approprié.

NON ↓

L'enfant est-il capable de boire ?

OUI →

1. Commencez k traitement par h sob tion SRO. comme dans k Plan ck Traitement 8.
2. Orientez l'enfant ven un centre où l recevra un traitement par perfusion N.

Avez-vous reçu une formation vows permettant d'utiliser une sonde nasogastrique de réhydratation

OUI →

1. Commence2 la réhydratation à taide de la sonde.
2. Si h perfusion IV peut être faite clans les environs, envoyez immédiatement l'enfant afin qu'il reçoive une perfusion.

NON ↓

URGENT : Orientez l'enfant vers un traitement par perfusion IV.

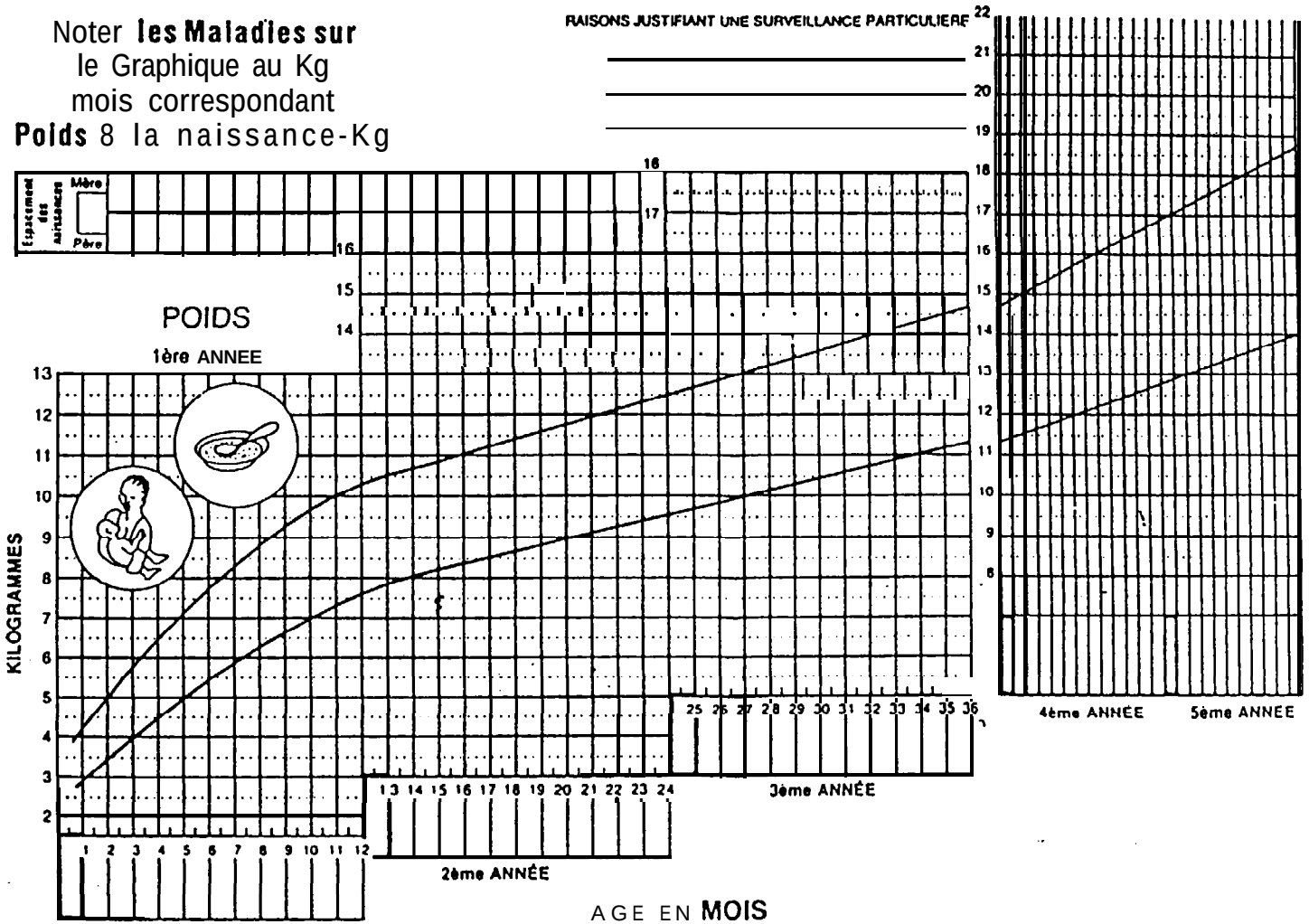
REMARQUE :

Si l'enfant a une forte fièvre, indiquez à la mère la façon de le rafraichir à l'aide dun linge humide et en l'éventant.

. Si l'enfant a plus de 2 ans et que le choléra existe actuellement danr votre zone, suspecter le cholera et donner un antibiotique approprié par voie orale dès que l'enfant est alcrte.

Source : Module OMS Traitement de la diarrhée.

Noter **les Maladies sur**
le Graphique au Kg
mois correspondant
Poids 8 la naissance-Kg



VACCINATIONS

BCG le : _____

Polio zéro le : _____

D. T Coq	Polio
1ère prise :	
2ème prise :	
3ème prise :	
Rappel :	

Rougeole le : _____

Fièvre jaune 17 D le : _____

Tétanos le : _____

AUTRES VACCINATIONS

Meningite le : _____

Cholera le : _____

DT TAB le : _____

LIST OF HIGH RISK FACTORS FOR PREGNANCIES AND BIRTHS
- Condensed Translation

Risk factors:

Obstetrical antecedents
- Caesarian
- still-birth
- >2 miscarriages
- sterility >5 years

Current pregnancy
- age <18 or >35 years
- over 8 children
- height <150 cm
- hemorrhage
- pre-eclampsia
- first child, mother >35 years

Associated diseases
- Hypertension > 140/90
- Diabetes
- Sickle-cell anemia

Social factors
- Single woman
- unfavorable socio-economic situation

Facteurs de Risques	G à R	A à R	TR	Suivi	Ref. suivi	Ref. accouchement
Antécédents obstetricaux						
Césarienne		X			X	XX
Enfant mort-né	X	X		X		XX
Avortement > 2	X			X	X	XX
Fausses couche > 2	X			X	X	XX
Stérilité de + de 5 ans	X			X	X	XX
Grossesse actuelle						
- age < 18 ans > 35 ans	X	X		X		X
- grd multiparite > 8 enfts	X	X		X		X
- taille < 150 cm		X	X	X		XX
- hémorragie	X			X		XX
- pré-éclampsi	X	X		X		XX
- primipare > 30 ans						X
Maladies associées						
- Hypertension > 140/90	X	X	X	X	X	XX
- Diabète	X	X	X	X	X	XX
- Drepanocytose	X	X	X	X	X	XX
Facteur sociaux						
- Femme seule (cél. ; Vve)	X	X		X	SS	
- condition socio-éco-défavorables	X	X		X	SS	

XX Medecin
X Centre médical avec entenne chirurgicale
SS Service Social
TRT : Traitement
A à R : Accouchement à risque
G à R : Grossesse à risque

2°) Fratrie

Enfants	Vivants					Décédés	
N°	Date	Terme	Sexe	Age	Santé	Age	Cause
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

Naissance

Lieu de l'Accouchement : Maternité ☐ Domicile ☐

Date: ..... à .....heures
à terme ou au .....mois de grossesse
durée travail :
Interventions obstétricales

Etat de l'enfant à la naissance :

			M	F
Apgar		Sexe	0	0
Poids de Nce :	Taille:	P.C. :		p.l,
	B.W.	G.S. Rh:		

A-t'il crié tout de suite ?
Etait-il cyanosé ?
A-t'il fallu le réanimer ?
Durée de la réanimation :
Délivrance

Poids de S.
• date de sortie

Particularités - Malformations

Régime:

0	**Sein**
0	**Allaitement Mixte**
☐	**Allaitement artificiel**

Conseils

Gestation

Dernières règles le :
Accouchement prévu :
Exsmens Pdrlodlques

Examens	1er Examen	2ème Examen	3ème Examen	4ème Examen
Date				
Tdlb				
Poids				
TA.				
Oedèmes				
Anémie				
Urines				
Hauteur Utérine				
Présent				
Bruit du cœur				
TV				
Promontoire				
B.W.				

Prévention

Paludisme : .....

Anémie : .....

Vacclnatlons : .....

		DATE
Antitétanique	VAT 1	
	VAT 2	
	VAT 3	
	VAT 4	
	VAT 5	

Autres : .....

Examens complémentaires

Dale	Nature de l'Examen	Résultats

MALARIA CONTROL PROTOCOL - Condensed Translation

Diagnosis according to level:

Village Health Post:
Fever over 37.5' C without apparent cause

Health centers without microscopy:
Fever over 37.5' C.
Shivering, hot, vomiting, generalized pains
Negative clinical exam for other fever-inducing diseases

Health centers with microscopy:
Fever over 37.5' C.
Presence of parasites in microscopic blood exam.
Absence of other causes of fever in clinical exam.

Hospital:
As above.
Other paraclinical exams negative.

JOB DESCRIPTIONS - Condensed Translations

child Survival Coordinator:

coordinate and manage the Child Survival project.
Maintain relations with partner organizations.
Ensure technical training of project personnel.
In collaboration with partners and superiors, prepare annual plans and DIP.
Supervise setting up of HIS.
Ensure coordination with other sectoral activities (credit, etc).
Write and submit monthly and annual reports.

Health Promoter:

Carry out family registration, prepare rosters, and up-date HIS information.
Monitor women and children in project area.
Organize and carry out health and nutrition training sessions.
Help establish village health committees.
Work closely with VHWs and other partners/resource people.
Write and submit monthly reports.
Other tasks as requested by supervisor.

Supervisor:

Organize, advise and supervise health promoters in the field.
Participate in promotion of child spacing methods.
Prepare monthly work plan and monthly reports.

Nurse/Midwife:

Implement activities related to high risk births, including pre- and post-natal consultations, family planning, and AIDS prevention activities.
Assist in trainins of TBAs and VHWs.
Up-date HIS information.
Maintain positive relations with partner organizations.
Write and submit monthly reports.,

HIS Coordinator:

Organize and supervise family registration.
Put in place HIS instruments.
Supervise ongoing collection of vital events and health information.
Supervise feedback of information to villagers.
Data entry, up-dates and analysis.
Provide HIS training to other project staff.
Provide information to project management as requested.

Resumes of Key Staff

Oliver ***Wilder - Field Office Director***

Experience:

1991-present: Field Office Director, Burkina Faso, Save the Children

1989-1991: Program Manager, Mali Field Office, Save the Children

1988-1989: Program Officer, Africa Region, Save the Children Headquarters (Westport, CT)

1987-1988: Program Assistant, Africa Region, Save the Children HQ

1986: Southern Africa Program Representative, Oxfam America (Boston)

1983-85: Regional Coordinator, Improved Cookstove Program, US Peace Corps (Senegal)

1982: Volunteer Coordinator, Headquarters, Emergency Relief Fund International (San Francisco)

Education:
Master's in International Administration (candidate), School for International Training, Brattleboro, VT
B.A. Political Science, Williams College, Williamstown, MA 1982

Issiaka Diallo - Impact Area Manager

Mr. Diallo, having been a field agent and then manager of the Regional Development Service (known successively as the ORD, the ex-ORD, and the CRPA) in northern Burkina Faso for twenty years, joined Save the Children as Deputy Impact Area Manager for Dori in 1987. In 1988, he became the Impact Area Manager, and was responsible for managing implementation of the large Child Survival 5 project. Mr. Diallo transferred to the Sapone Impact Area in July of 1991.

Jean-Pierre Bembamba - Health Promoter Supervisor

Mr. Bembamba is a Registered Nurse with six years' experience in charge of the health center in Kokologho Department in Boulkiemde Province of Burkina Faso. He has been coordinator of Save the Children's primary health care activities in the Sapone Impact Area since 1988.